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SOLUTION-FOCUSED BRIEF THERAPY AS AN ALTERNATIVE TO CLINICAL SOCIAL WORK IN CHILE

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SOLUTION-FOCUSED BRIEF THERAPY AS AN ALTERNATIVE FOR CLINICAL SOCIAL WORK IN CHILE

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Dedication

To my children Sol and Simon, my husband Evin, my parents Paula and Jorge, my siblings Paula and Jorge, and my parents in law Eugenia and Ibar. Your unconditional patience, love, and care made this achievement possible. Thank you.

To volunteer people who participated in these studies.

A mis hijos Sol y Simon, mi esposo Evin, mis padres Paula y Jorge, mis hermanos Paula y Jorge y mis suegros Eugenia e Ibar. Su paciencia, amor y cuidado incondicional hicieron posible este logro. Gracias.

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Solution-focused Brief Therapy as an Alternative for Clinical Social Work in Chile

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This manuscript consists in a three-paper dissertation that compiles relevant research and practice regarding solution-focused brief therapy (SFBT) with Latinos and Latin Americans who present alcohol use disorders. In this sense, the first paper is a systematic review on all the empirical studies of SFBT with Latinos that have been published and not published from January 1990 to December 2014 and uncovers the scarcity of empirical studies on SFBT in Latin American countries. Findings suggest that this approach is a promissory alternative to intervene with Latinos and Latin American people who present varied psychosocial problems. More empirical studies examining different conditions will inform regarding its effectiveness. The second article corresponds to the description of an exploratory linguistic adaptation of the SFBT approach for Chilean, clinical, and vulnerable population who are alcohol users, following a qualitative approach. Findings suggest that this population understood main SFBT techniques after changing phrasing to make them clearer and simpler. In addition, practitioners should consider issues such as stigma of alcohol use in women, inclusion of family members in the treatment process, and being attentive to what client wants; all of these considerations are consistent with SFBT. The third article presents a pilot implementation of the approach with the

population to which the approach was culturally adapted, four social workers were trained in SFBT and eight individuals with alcohol problems received a three-session SFBT. Data were analyzed using visual analysis, percentage of non-overlapping data, linear regression, and hierarchical linear modeling. Main findings suggest that individuals receiving SFBT trended to increase their abstinent days, decrease their depression scores, consequences of alcohol use, and improve their self-reported wellbeing. These three papers build on the small literature available until now regarding SFBT with Latin Americans, and sit the basis for continue to build more empirical research that provides Latin American practitioners with an evidence-based intervention to implement with their clients.

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CHAPTER 1: INTRODUCTION

Solution focused brief therapy is a contemporary approach that emerged towards the beginning of 1980's and has its roots in brief family therapy that relied on systems and communication theories (Bavelas et al., 2013, De Jong & Berg, 2013). Among the main principles of this approach—it focuses on solution rather than problems; it is strengths-based; it focuses on present and it is future oriented; there are exceptions to the problems; solutions are not necessarily related to the problems; therapists do not diagnose the problem, they assist clients to generate solutions through the conversation instead. From SFBT view, clients have their own mechanisms to generate solutions; therefore, strategies to achieve clients' goals are defined by them (Bavelas et al.). In addition, the therapist meets the clients where they are, and works with and enhance clients' competences (Hendrick, Isebaert, & Dolan, 2012).

Alcohol use disorders (AUD) are a major worldwide concern that constitute the main cause for several diseases around the world (World Health Organization, 2009). Alcohol use is associated with 3.3 million deaths yearly, being the cause of death of 5.9% of all deaths around the world (World Health Organization, 2014). In addition, there are estimated percentages of certain diseases and health situations that would have not occurred if individuals had not drank alcohol. For example, 50% of liver cirrhosis, 31% of oral cavity and pharynx cancers, 27% of pancreatitis, 20% of interpersonal violence, and 15% of traffic injuries are attributable to alcohol (World Health Organization, 2014). For Latin America and the Caribbean, alcohol ranks as the fourth leading risking factor

being exceeded by dietary risks, high blood pressure, and high body mass index (Institute for Health Metrics and Evaluation et al., 2013).

Research in developed countries has shown that brief psychosocial interventions intended to help individuals to change patterns of alcohol use are potentially one of the most cost-effective and cost-saving treatments in health care, requiring little training and being possible to implement in brief time (Solberg, Maciosek, & Edwards, 2008). Their effectiveness in Latin American countries, however, needs to be established in research studies since the introduction of these interventions is new in this continent. Moreover, the implementation of BIs for AUD varies across Latin American countries. Among them, only four—Chile, Dominican Republic, Panama, and Venezuela—indicated to have incorporated this activity as a routine in their primary care services (World Health Organization, 2010). Therefore, the challenge is not only in terms of research but also in terms of implementation of policies that establish the basis to develop research across Latin American countries.

This manuscript consists in a three-paper dissertation that compiles relevant research and practice regarding solution-focused brief therapy (SFBT) with Latinos and Latin Americans and its implementation with individuals who present alcohol use disorders. The second chapter, named, "Solution-focused brief therapy with Latinos: a systematic review" presents all published and non-published studies that were available from 18 databases and other sources between January 1990 and December 2014. After eliminating repeated studies, 2,277 titles were found. Forty-four articles were selected for

a full review and only six studies met the inclusion criteria, such as referring explicitly to SFBT as one approach implemented in the intervention. Three studies were developed in Latin American countries (Jara, 2010; Seidel & Hedley 2008; Schade, Torres & Beyebach, 2011) whereas the other three studies were implemented with Latinos in the United States (Harris & Franklin, 2003 & 2009; Springer, Lynch & Rubin, 2000).

The fields in which SFBT has been implemented with Latinos referred mainly to, adult behavioral health interventions, children and adolescents in school settings, and couples counseling. Even though this systematic review does not allow for strong conclusions regarding the effectiveness of SFBT with Latinos due to the small amount of studies that were found, it showed the growing interest that practitioners and researchers who work with Latinos have on implementing the approach. This implies that the approach has been translated to Spanish, however, no linguistic or other type of cultural adaptation of this approach was reported in any of the reviewed studies. Therefore, and in accordance with the natural cultural sensitiveness of the SFBT approach (Corcoran, 2000; Oliver & McNichols, 2011), the author of this dissertation states that a linguistic adaptation and consequently Spanish version of the manual for SFBT practitioners should be developed.

The third chapter, "Solution-focused brief therapy for Chilean primary care patients: exploring a linguistic adaptation" involves the whole linguistic adaptation process of SFBT to Chilean vulnerable population. The author of this dissertation has recently developed a comprehensive review on brief interventions for alcohol use in Latin

American countries. It is particularly interesting that none of the studies presented any information regarding a linguistic adaptation process. This becomes relevant in Latin America because most intervention approaches have been created in English-speaking countries by English speaking researchers and practitioners and most of the evidence has been obtained from studies with non-Latino subjects, with some exceptions in which studies have shown that brief interventions, and particularly motivational interviewing is effective with this population (Lee, et al., 2011). However, other research has shown that Latinos living in the United States and Latinos living in their own countries reported different reasons associated to alcohol use (Lee et al., 2013). In this line, new studies that examine the implementation of linguistically or culturally adapted brief interventions for alcohol use and that contribute to enhance the extant research are extremely needed.

The linguistic adaptation presented in this third chapter included a translation and back translation of the main interventions of SFBT done by the researcher and bilingual social workers. This translation was examined through cognitive interviews with individuals from an underserved community, whom were be exposed to the questions employed in the SFBT interventions. The cognitive interview is a method that helped the researcher to capture the understanding of the interventions and to clarify with the interviewees the best wording for the translated questions that are at the core of the SFBT interventions, making sure that they keep the spirit of the approach. The cognitive interviews were complemented by focus groups in which the experiences and cultural aspects of alcohol use in Chilean individuals was inquired. Issues such as naturalization

of alcohol use in men and stigmatization of alcohol use in women, as well as the participation of significant others, and the inclusion of what is important to clients in alcohol treatment were revealed through this stage of the study. The SFBT approach has a treatment manual that is constantly updated by the Solution-Focused Brief Therapy Association. In this vein, the analysis of the responses sit the basis for the development of a Spanish-written manual of SFBT which was the main product of this stage and the main instrument to train social workers for a pilot study on the implementation of the approach.

Consequently, the fourth article, "Solution-focused brief therapy for individuals with alcohol use disorders in Chile: a pilot study" reports an empirical study on the implementation of SFBT by social workers in a primary clinic with individuals who use alcohol. In Latin America, only nine studies analyzing brief interventions for AUDs have been found through the previous work of the author. These studies reflected the current trend in terms of intervention approaches for alcohol use that is observed worldwide, for example, motivational enhancement, cognitive behavioral, and an incipient development of solution-focused brief therapy. From that previous work, the author concluded that in Latin America there is a dearth of research in this topic because only few studies and with limited research methods as well as intervention approaches have been conducted in the last 25 years. Indeed, no comparisons between approaches have been published. One of the nine studies that were found in that review implemented SFBT as the primary intervention, showing that individuals with higher levels of biopsychosocial risk

presented better results after the intervention (Cordero, Cordero, Natera, & Caraveo, 2009). Other studies show mixed results, being unclear whether a very brief intervention (20-minute single session) is better than no intervention and whether longer interventions are more effective than single sessions. None of the studies found in Latin America reported procedures for linguistic adaptation of their interventions. This article will contribute with the pilot implementation of SFBT in Chile, delivered by Chilean social workers in Spanish language for individuals who use alcohol. The methodology of this study will be a single-case design.

These three chapters constitute a first step for a bigger body of knowledge that is starting to evolve in two main lines that this dissertation puts together. First, it presents the empirical research on SFBT with Latinos developed until now. Second, it proposes the systematization of an explorative linguistic adaptation of the SFBT approach for vulnerable population in Chile, which was implemented in a pilot study with individuals who have alcohol use disorders. The SFBT approach has been implemented with alcohol users in several countries such as The United States, Belgium, and México, showing positive trends yet lacking of linguistic or other types of cultural adaptations to diverse groups. The pilot study presented in the third chapter of this dissertation contributes to address this issue. Chapter five is a synthesis and brief review of the main contribution of each study reported in prior chapters is presented.

Chapter 2: Solution-Focused Brief Therapy with Latinos: A Systematic Review

INTRODUCTION

Solution-focused brief therapy (SFBT) is a strengths-based intervention that emerged from the clinical work of Steve de Shazer, Insoo Kim Berg and their colleagues between 1978 and 1984 at the Brief Family Therapy Center (BFTC) located in Milwaukee, Wisconsin. The clinical techniques and change process of SFBT has more recently been explained in a treatment manual that describes the specific interventions and the therapeutic techniques of SFBT (Trepper et al., 2012). The most recent version of the manual is available from the Solution-focused Brief Therapy Association (SFBTA.org) and also describes the research that supports the effectiveness of SFBT. During the past three decades research on the effectiveness of SFBT has grown significantly for both children and adult populations and shown promising results (Bond, 2013; Franklin, Trepper, McCollum, & Gingerich 2012; Gingerich & Peterson, 2013).

SFBT has increasingly been used in countries outside the United States with different ethnic groups but the current systematic reviews and meta-analyses have not studied how effective SFBT may be with specific ethnic groups or ethnic minority populations. Franklin and Montgomery (2014) suggested that this dearth of information may be due to lack of attention to the effectiveness of SFBT with ethnic groups and to the small numbers of participants in SFBT studies that may further prohibit moderator analysis. The literature on SFBT would suggest, however that it is important to study the

potential effect of SFBT in different countries and among specific ethnic groups. A website in the United Kingdom that catalogues large numbers of world-wide SFBT studies indicates that over 1,900 articles have been published on SFBT in several different languages and, as of 2015, that there were 194 outcome studies (McDonald, 2015).

The practice literature further suggests that SFBT is being practiced in many different countries including diverse European nations such as Belgium, Italy, Germany, Spain and England (e.g., Burr, 1993; de Shazer & Isebaert, 2003; George, Iveson, Ratner, & Shennan, 2009; Shennan & Iveson, 2012; Ulivi, 2000). There is literature from Asian countries such as Japan, Korea, and China (e.g., Hung & Sung, 2007; Kim et al., in press; Mishima, 2012; Zhang et al., 2015). A recent systematic review from Mainland China, for example, discussed how SFBT was being implemented and studied within mental health, health care, schools, and in children's services (Zhang et al., 2015). Authors have also translated SFBT into Spanish (e.g., Beyebach, 1999; Rodriguez & Beyebach, 1994) so that it can be implemented in Spanish speaking countries, yet little is known about the practice of SFBT in Latin America. The potential benefit of SFBT with Spanish Speaking and Latino populations in the United States and Latin America is a particularly important area of study because Latinos are the largest ethnic group in the United States and 74% of Latinos in the US speak Spanish at home (US Census Bureau, 2014). In addition, Spanish has become the second most spoken language in the world as native language, preceded by Chinese and followed by English (Lewis, Simons, & Fennig, 2015). These facts

suggest that more attention is needed on how SFBT works with Latinos and its implementation to Latin America, and other Spanish speaking countries.

SFBT with Latino Populations

Corcoran (2000) described how the practice guidelines of SFBT harmonizes with Mexican American culture, such as, the consideration of an interpersonal context (like the family) and an emphasis on behavior change, cooperation, goals that are meaningful for clients, and a focus on future orientation and behavior rather than feelings. Other authors have also described how SFBT is adaptable to the inherent aspects of the Latino culture such as *familismo* (the sense of loyalty, commonality, cooperation, and interdependence between family members), spirituality and religiosity, community and collectivism, and *personalismo* (respect for relationships and reciprocity; Oliver & McNichols, 2011).

There are outcome studies that have been completed in the United States where the samples are predominately Latino youths (e.g., Harris & Franklin 2003, 2009; Springer, Lynch & Rubin, 2000) suggesting that SFBT can be successfully applied with Latinos. A research team from Spain conducted other studies with Spanish speaking populations including specific interactions during therapy sessions (Beyebach & Escudero, 1997; Herrero de Vega & Beyebach, 2004) and applications of SFBT in family therapy (Beyebach et al., 2000; Beyebach, Rodriguez, Palenzuela, & Rodríguez-Arias, 1996). Other studies from this team have examined the implementation of SFBT with individuals with mental health disorders, particularly with deaf individuals with depression (Estrada & Beyebach, 2007; Estrada et al., 2013) and with individuals with

somatoform symptoms (Schade, Beyebach, Torres & Gonzalez, 2009; Schade, Torres & Beyebach, 2011). The latter studies were developed in Chile, suggesting that some research is being conducted with Spanish-speaking populations in Latin America as well. Estrada, Beyebach, and Herrero de Vega (2006) further reviewed the outcome research on SFBT for Spanish speaking population; however, most of the studies reviewed were with English-speaking clients and were translated into Spanish for the purpose of educating Spanish-speaking professionals on the potential effectiveness of SFBT.

Purpose of the Study

SFBT is being implemented with Spanish-speaking populations but no reviews of SFBT have been conducted on Latino populations. The purpose of this paper is to identify all the experimental and quasi-experimental studies on SFBT with Latino populations both in the United States and in Latin American countries. The current study serves as a bridge between the application of SFBT in Spanish and English, which provides an opportunity for English-speaking practitioners and researchers to learn about how SFBT is being practiced and researched in Latin America. This systematic review will further add to knowledge about effectiveness of SFBT with Latino populations, which are a large worldwide population of interest.

METHOD

Eligibility Criteria

Latinos were defined as individuals who self-define as Hispanics, Latinos, Mexican-American, or native from any Spanish-speaking country from North, Central or

South America. SFBT literature published from January1990 to December 2014 was searched, including studies from Latin American countries. Eligibility criteria for identifying all the studies on SFBT with Latinos included the following: 1) articles that explicitly referred in their title or abstract to Solution-focused brief therapy with Hispanics, Latinos, or Spanish-speaking populations[1]; 2) article titles that referred to culturally sensitive SFBT interventions or to multiethnic or multiracial SFBT interventions; and 3) articles referring to SFBT in which one or more authors had a Hispanic last name. These initial criteria were used to further identify studies specifically to SFBT with Latinos in the initial literature search process.

Three inclusion criteria were used in selecting the articles for further review. The first, articles needed to identify part or all of the intervention as using SFBT and the use of specific SFBT techniques that have been identified by the SFBT treatment manual such as scaling questions, solution-focused goals, and homework (Trepper et al., 2012). Second, articles needed to state that the SFBT intervention was applied to Latino population. Third, studies needed to use experimental or quasi-experimental designs to examine the effectiveness of SFBT with Latino population. In addition, four exclusion criteria were applied: 1) articles that referred to theoretical discussion regarding solution-focused brief therapy; 2) articles that presented SFBT done in Spain; 3) articles that

[1] This eligibility criteria did not intended to exclude the other eligibility criteria, however it was an aspect that we took in account and that helped us to guide our search.

referred to description of the implementation of SFBT with one client or case studies; and 4) articles that included less than 85% of Latinos among the participants.

Search Strategy

The search strategy involved 4 stages. In the first stage, twelve search engines for academic publications were utilized (EBSCO (Mediclatina, Chicano, Health Source Nursing, Psychology and Behavioral Sciences, and Academic Search Complete); Web of Science (Core Collection); Science Direct; Pubmed; Academic Journal Databases; Open Acces; Dialnet; Redalyc; Flacso Andes; SciELo; Social Service Abstracts). A list of key terms in English and Spanish was defined to conduct the search of scholar articles that referred to solution-focused brief therapy with Latinos. This list contained: "Solution-focused therapy," "Solution therapy," Solution brief therapy," "Psychotherapy solutions," "Terapia centrada en soluciones," "Terapia breve centrada en soluciones," "Terapia soluciones," Terapia familiar," "Terapia sistemica," "Terapia enfocada en soluciones," Terapia breve," "Psicoterapia soluciones." The list of key terms was searched in titles of articles. Since the search was intended to capture literature that may not be easy to find, we intentionally did not select any limiters. During this search, the main author among Spanish publications was identified to be Mark Beyebach. Since only few publications for Latino populations were found, "Beyebach" was included as the last key term to search in "all text" across the selected search engines.

Even with the existing strategies a small number of articles regarding Latino populations were retrieved in the first stage of the search. Hence, a second stage consisted

in a specific search on the scholar section of the public on-line search engine Google (Google Scholar) in order to increase the numbers of documents found. Due to the constant change and breadth of this search engine, the terms employed were more specific and limited than in the first stage. The advanced search tool was employed in this case. It allowed us to search for specific complete phrases in the whole text, namely, "Solution-focused therapy" AND "Hispanics," "Solution-focused therapy" AND "Latinos," "Terapia centrada en soluciones" AND "Beyebach." In order to increase the identification of articles, two others inclusion criteria were added in this stage. The first, articles in Spanish that referred to brief, integrative, constructivist, collaborative or systemic therapy in the title were selected to have their abstract reviewed because it was found in the first stage that solution-focused therapy was often offered in conjunction with these approaches. Second, key authors that were identified in the first stage that had used solution-focused techniques in studies were added to the search because it was also discovered during article screening that these authors had studies using solution-focused techniques that were referred to by other terms in Latin American literature. For example, articles that have Margarita Herrero de Vega and Mark Beyebach, as one of the authors, were selected to an abstract review.

The third stage comprised a search for dissertations and theses in 3 search engines: Openthesis, Proquest Dissertations and Theses (full Text), and Center for Research Libraries. The same key terms and inclusion and exclusion criteria utilized during the first stage were applied in this third stage.

1.	Acta Colombiana de Psicología
2.	American Journal of Family Therapy (2000-2014)
3.	Child and Adolescent Social Work
4.	Families in Society (2000-2014)
5.	Families, systems and Health (2000-2014)
6.	International Journal of Solution-Focused Practices
7.	International Journal of Hispanic Psychology
8.	Investigación Valdizana (2007-2011)
9.	Journal of Professional Counselling
10.	Journal of Systemic Therapies
11.	Mexico Quarterly Review (Psicología all those that were available)
12.	Revista Salud Mental (1983-2013)
13.	Revista Ajayú March 2003-March 2014
14.	Revista de Psicología (Universidad Cesar Vallejo, Peru) 2005-2013
15.	Revista Elactrónica Iztacala
16.	Revista Internacional de Psicología
17.	Revista Latinoamericana de Psicología
18.	Revista Terapia Psicológica (2004-2013)

Table 1: List of Journals Searched.

The fourth stage involved searching other sources beyond key words and electronic search engines. It included 1) a thorough review of references of articles selected for a whole review; 2) a one-to-one contact via e-mail to all the authors that have their e-mails available on their publication; 3) a thorough review of the table of contents of each journal that published an article referring to SFBT in Latin American countries and other journals that potentially could publish articles on Solution-focused brief therapy from Latino America (see list of journals in Table 1); 4) a search for web pages related to SFBT; and 5) one-to-one contacts with people working in SFBT in Latin

America that the author had knowledge of. The criteria for inclusion and exclusion described for the first stage and second stage were applied in this stage.

The authors created a coding form to summarize and analyze the findings from the articles. This coding form is available from the first author and includes the type of report; country of the study; demographic information; inclusion and exclusion criteria; providers; intervention characteristics; study design; treatment format; duration of treatment, SFBT interventions implemented; outcome measures; and main results. Studies selected for a full text review were coded using the coding form by two independent raters and when there were disagreements about the coding these differences were resolved by subsequent discussion. The study methods were presented and discussed with solution-focused researchers at a research day hosted by the Solution-focused Brief Therapy Association and further discussed with a researcher from Latin America.

Several studies included in this systematic review reported effect sizes and are included in our results section. Effect sizes were calculated using Comprehensive Meta-Analysis software 2.0 (Borenstein, Hedges, Higgins, & Rothstein, 2005) when primary studies did not report them. Hedges's *g* effect sizes were calculated from means and standard deviations presented in the articles and reported in our results section. The effect size statistic standardizes reported study outcomes to allow interpretation, comparison, and analysis of results across studies (Lipsey & Wilson, 2001). Effect sizes go beyond the typical statistical significance normally reported with *p*-values by estimating the

magnitude and direction of the treatment effect (Littell, Corcoran, & Pillai, 2008). Effect sizes were interpreted based on classification by Cohen (1988), with 0.20 or less indicating a small effect size, 0.50 medium, and 0.80 and above large.

RESULTS

Figure 1 shows the results of the all four search strategies. The whole search allowed 2,984 titles, which after excluding all those that were repeated are 2,277. After initial screening, 160 abstracts were included for additional review and 115 articles were further excluded leaving 44 articles for a full text review by two independent coders. The final review resulted in six studies, four RCT's and two quasi-experimental research studies that met the criteria for this review. SFBT interventions implemented within the studies were brief and the individual interventions had on average 3 sessions while group interventions ranged from 3 to 8 with an average of 6.5 sessions. The sample sizes of the studies were varied ranging from 10-256 with most studies having samples less than 100. See table 2 for a detailed summary of the six studies.

As it was part of the inclusion criteria, all of the studies in this review explicitly referred to the implementation of SFBT as a primary intervention or in combination with other therapeutic approaches. Two studies used SFBT as a primary intervention (Seidel & Hedley 2008; Jara, 2010) whereas four studies combined SFBT with other therapeutic approaches (Harris & Franklin, 2003, 2009; Schade, Torres, & Beyebach, 2011; Springer, Lynch, & Rubin, 2000).

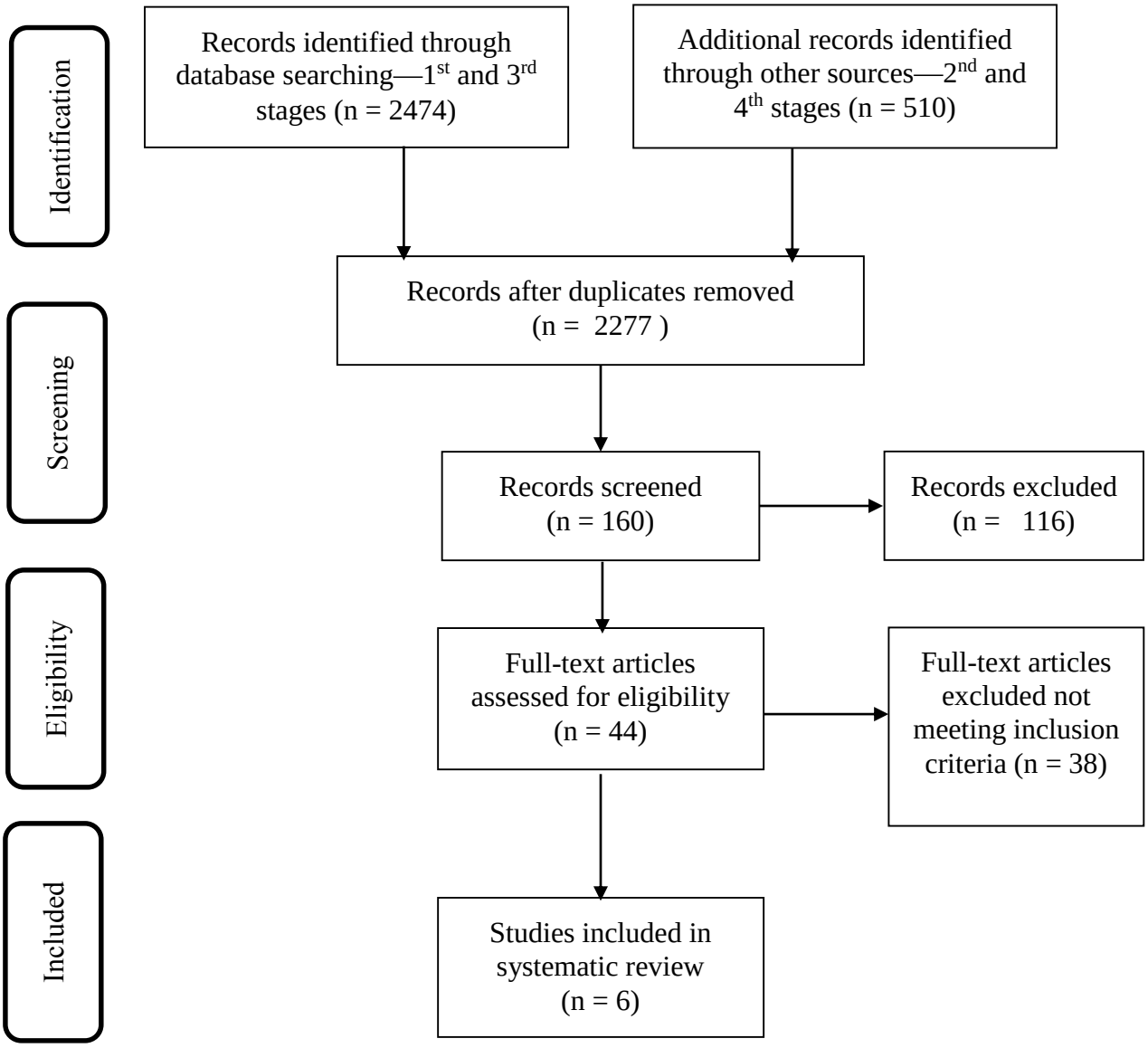


Figure 1: Flow diagram showing the sources and number of studies in the selection process.

Participants in the Studies

A total of 398 individuals participated in the six studies, from which 99% were Latinos and 1% was Caucasian. As for gender, 92% (N = 367) of participants were female. Studies included were conducted with several ranges of ages, such as, elementary school-age children, middle and high school-age adolescents, adults, and older adults. The targeted populations and targeted problems varied as well as the settings in which the interventions were developed. Three target groups and problems were found, including adult behavioral health, children and adolescents at school, and couples intervention.

SFBT across Target Populations and Problems

Adult behavioral health

One study conducted individual interventions (Schade et al., 2011), whereas another study conducted a group intervention (Seidel & Hedley, 2008). The focus and type of population of the studies were somatoform symptoms in adults (N=256) in primary care (Schade et al., 2011) and stress, mental health symptoms, and goals in older adults (N=20) in an urban community (Seidel & Hedley, 2008). Even though targeted populations and settings varied across adult mental behavioral health interventions, the average number of sessions reported was three.

The outcomes reported in these studies also varied according to the focus of each intervention. Thus, the study by Schade and colleagues (2011) observed that costs (e.g., medical visits costs, medication costs, and costs of complimentary medical analyses) were significantly lower in the experimental group after treatment ($p < .05$) and at 12-month follow up ($p < .001$). Likewise, overall medical cost was significantly lower in the

experimental group than in the control group after treatment and at 12-month follow-up. The effect size reported in this variable was above 0.80, (Schade et al., 2011), which Cohen (1988) considers a large effect size. In the study conducted by Seidel and Hedley (2008), results showed that individuals who participated in the three group sessions of SFBT were significantly more likely to reflect therapeutic changes, assessed by the OQ-45.2 (p = .006) and more likely to report successfully goal achievement than those in the control group (p = .041).

Children and adolescents at school

The three studies with children or adolescents were conducted in United States schools with Latino students. Researchers implemented weekly six-to-eight-session group interventions oriented to treat participants' psychosocial aspects (Harris & Franklin 2003, 2009; Springer, Lynch, & Rubin, 2000). Two studies referred to the assessment of the same intervention but different groups of pregnant and/or parenting adolescents (Harris & Franklin, 2003, 2009). In the study by Harris and Franklin (2003), grade average and rate of school attendance were significantly higher in the SFBT group in post-test (d = 0.47); the SFBT group also showed a higher rate of school attendance at six-week follow up (d = 0.48). These effect sizes are considered medium. In this research, adolescents participating in the SFBT group were more likely to have better coping skills as measured by the A-COPE (d = 0.79) and problem-solving skills as measured by the SPSI-R (d = 1.00) than those in the control group at post-test and follow-up showing large effects. In the study by Harris and Franklin (2009) adolescents who participated in

the SFBT intervention were more likely to improve and have higher school average ($p <$ .001) and school attendance ($p < .001$) than the control group at post-test. The intervention reported by Springer and colleagues (2000) comprised 4th grade children who had an incarcerated parent. In this study, even though children participating in the SFBT group reported a significant increase in the score of the self-esteem between pre-test and post-test assessments and also reported an increased self-esteem than the control group, no significant differences were found between groups at the end of treatment. Despite this, the effect size for the self-esteem was 0.57, which is considered a medium effect. These three studies showed positive trends regarding performance at school and psychosocial aspects in children when participating in group interventions with SFBT components.

Couples

The dissertation by Jara (2010) involved a six-session group therapy for married couples participating in a Catholic church in Peru using an RCT. The aim of the group was to improve the marital satisfaction of participant couples, represented in three dimensions around expectancies that partners have regarding their counterparts. Marital interaction refers to communication styles and time dedicated to the relationship. Emotional aspects refer to behaviors associated to different emotional states, such as sadness, anger, or concern. Structural and organizational aspects refer to behaviors related to habits, customs, and rules (Pick de Weiss & Andrade Palos, 1988). Couples participating in the SFBT group improved significantly their marital satisfaction at post-

test compared to the control group ($p < 0.01$), who did not receive any treatment. The original study did not provide effect sizes for the outcomes but we were able to calculate effect sizes based on means and standard deviations provided in the study. The effect sizes for the three outcomes were $g = 0.50$ for marital interaction, $g = 1.42$ for emotions, and $g = 0.47$ for structure and organization. Those SFBT couples had a medium treatment effect for marital interaction and structure and organization and a very large treatment effect for emotions as compared to the control group.

Study type	Research Design	Country & Sample	Intervention	SFBT Techniques	Measures	Results summary	Effect size
Schade, Torres & Beyebach (2011) *Journal article*	RCT Control group: Treatment as usual pre-test post-test and 12-month follow up	Chile *Patients with somatoform symptoms* N=256	Combined with strategic, psycho-education & counseling *3 Individual sessions*	Goals Homework Scaling	Number of Visits to Primary Care team; Total Number of Medical Analyses, and Medications Used.	Results showed a reduction in number of visits, total number of medical analyses, and medications used by patients who received SFBT. The costs of overall medical expenses for SFBT patients were reduced, but the costs for patients in the control group remained the same at post-test and at one-year follow-up.	Overall medical cost=0.80
Seidel & Hedley (2008) *Journal article*	Quasi-experimental pre-test post-test	Mexico *Older Adults* N=20	Only SFBT *3 Group sessions*	Goals Focus on what is better, Miracle question, Scaling Exceptions Relationship questions Compliment	Stress appreciation scale for older adults (SAE-A); Outcome questionnaire (OQ-45.2); Participant and assessor problem severity rating (PPSR, APSR); Participant goal achievement rating (PGAR).	SFBT group was more likely to report higher score in the PGAR than the control group. SFBT group also showed higher scores in the overall OQ, PPSR, and APSR compared to their scores before treatment. The SFBT group showed a trend towards clinical significance for OQ. Though few significant differences were found between groups, the trend towards larger effect sizes in comparison to the control group allow to infer that older adults in the SFBT group benefitted from the intervention.	SAE-A=0.05 OQ=0.53 OQ SD=0.61 OQ IR=0.31 OQ SR=0.13 PPSR=1.10 APSR=1.19

Table 2: Summary of SFBT studies on Latinos.

Study type	Research Design	Country & Sample	Intervention	SFBT Techniques	Measures	Results summary	Effect size
Harris & Franklin (2009) *Journal article*	Quasi-experimental pre-test post-test	United States *Pregnant or parenting Adolescents* N=19	Combined with cognitive behavioral approaches *8 Group sessions*	Homework	School Attendance; Grade Average	School attendance and grade average significantly increased among SFBT group. Comparison group's attendance and grades decreased after the intervention. Differences between groups after treatment were significant. SFBT was valued and well received by participants.	School attendance= 0.99 Grade average= 0.68
Harris & Franklin (2003) *Journal article*	RCT, Control group: regular case management pre-test post-test and 6-week follow-up	United States *Pregnant or parenting Adolescents* N=73	Combined with cognitive behavioral approaches *8 Group sessions*	Homework Goal Compliments Relationship questions	Rational problem solving (RPS); Adolescent coping orientation for problem experiences (A-COPE); School Attendance, School Grade, Social desirability.	Problem solving, coping, school attendance and grade average showed significant differences between SFBT and control groups. Whereas adolescents in the SFBT group improved scores in all measures, adolescents in the control group maintained or dropped their scores at posttest. Effect sizes for all measures were reported as medium and large. Significant differences were maintained at follow-up.	A-COPE=0.79 SPSI-R=1.00 School attendance=0.47 Grade average=0.48

Table 2, cont.

Study type	Research Design	Country & Sample	Intervention	SFBT Techniques	Measures	Results summary	Effect size
Springer, Lynch & Rubin (2000) *Journal article*	Quasi-experimental pre-test post-test	United States *Children with incarcerated relative(s)* N=10	Combined with interactional and mutual aid approaches *6 Group sessions*	Goal Miracle question Scaling Focus on what is better Homework Compliments	Hare Self-Esteem Scale (HSS)	Children participating in the SFBT group reported higher scores in the HSS at post-test compared with their pre-tests scores. However, no significant differences were found between groups at posttest for self-esteem.	HSS=0.57
Jara (2010) *Dissertation*	RCT, Control Group: regular participation in church group. pre-test post-test	Peru *Couples* N=20 indiv.	Only SFBT *6 Group sessions*	Goal Miracle questions Scaling Exceptions Compliments Homework Focus on what is better	Marital satisfaction 3 subscales: marital interaction; partners' emotional aspects; and partners' structural and organizational aspects.	Significant differences were found in marital interaction, partners' emotional aspects, and partners' structural and organizational aspects. Whereas the couples participating in SFBT group perceived improvement in all three areas of marital interaction, the couples in the control group maintained the same scores.	Marital interaction= 0.50 Emotions= 1.42 Structure & Organization= 0.47

Table 2, cont.

DISCUSSION

This article reviewed outcome studies on SFBT with Latinos in the United States and in Latin American countries. Three main areas of intervention were identified, adult behavioral health interventions, children and adolescents in school settings, and couples counseling. The review showed an increasing interest in using SFBT in Latin America and that studies on SFBT are emerging on Latino populations, however, the research with experimental and quasi-experimental research designs that study the effectiveness of SFBT with Latinos is small in number with only six studies found in a systematic literature search.

Rationales that researchers included in this systematic review gave for studying SFBT with Latinos were related to mainly two aspects. The lack of knowledge regarding the effectiveness of SFBT with Latino populations in the United States and in Latin America and the expectations to enhance the quality of services received by disadvantaged populations. Consistent with these rationales, Latinos remain one of the most vulnerable groups in the United States, having lower income, education, access to health insurance and citizenship (Grieco et al., 2012) and there is a need to study SFBT interventions with this population. The lack of study of SFBT with Latinos and other ethnic groups has been cited as a weakness in the research (Franklin & Montgomery, 2014) and is also inconsistent with the practice literature that suggests that SFBT is being used in many different countries with diverse racial and ethnic groups. For this reason, the current review on Latinos fills an important gap in literature regarding the suitability and effectiveness of SFBT with diverse populations.

Four out of six studies in this review with Latinos presented SFBT combined with other therapeutic approaches. The three studies in the United States (school settings) and the study in Chile (primary care) reported SFBT combined with other approaches such as cognitive-behavioral, interactional, mutual aid, strategic family therapy, psychoeducation, and counseling. While these studies make it more difficult to evaluate the efficacy of SFBT, authors suggested that SFBT worked well in combination with other approaches and was effective with the targeted populations and problems in schools and primary care. Studies that reported interventions with only SFBT were conducted in Latin America, with adult population (older adults and couples), and employed control groups that did not receive another type of intervention. The outcomes reported by these studies showed positive results in the effects that SFBT has among older adults presenting psychosocial problems and couples aiming to improve marital satisfaction. The study by Schade and colleagues (2011) on the effects of brief intervention in primary care that reduces mental health symptomology may be particularly important for Latin America because important mental conditions such as depression and anxiety are addressed at this level of health services (Alarcon, 2003; Minoletti, Rojas, & Horvitz-Lennon, 2010). Moreover, these conditions can be efficiently and effectively prevented and treated in primary care through brief interventions.

By reviewing the extant studies from Latin America, this article builds on knowledge from studies that were conducted in North American and European countries. As such, it may help to guide the future directions for SFBT interventions and research

taking into consideration how the approach is being used across cultures. The RCT Chilean study by Schade and colleagues (2011) builds on the knowledge developed in Spain by Real, Rodrigues-Arias, Cacigas, Aparicio, and Real (1996) that showed the cost-effectiveness of a brief intervention in primary care. However, the study by Schade and colleagues (2011) is slightly different because it includes SFBT combined with strategic approaches, while the Real et al. (1996) Spanish study did not include SFBT elements and was implemented with European population. The quasi-experimental, Mexican study by Seidel and Hedley (2008) extends applications of SFBT to older populations and builds on interventions that have been done in the US where SFBT is used to treat depression, isolation, and psychosocial problems in older adults (Bartsch, Rodgers, & Strong, 2013). This study suggests that SFBT is suitable for older adults, who would enhance their mental health by participating in a three-session SFBT group.

The RCT Peruvian study by Jara (2010) compliments other research on couples counseling in the United States with Caucasian couples (e.g., Zimmerman, Prest, & Wetszel, 1997) and with varied racial/ethnic couples (e.g., Naude, 1999). This study sought to work with couples who did not present an initial complaint and were participants of a religious community showing that SFBT may be compatible with a religious setting and in a group modality and can be used as a preventive strategy to strengthen relationships and enhance marital satisfaction. Interestingly, the one RCT and two quasi-experimental studies that were completed on Latino youths in schools were conducted in the United States (Harris & Franklin, 2003, 2009; Springer, Lynch & Rubin,

2000) and the authors did not find any studies in schools in Latin America. This may be due to lack of counseling resources in schools and also to the fact that the research on the applications of SFBT in schools has not been translated into Spanish. These studies targeted psychosocial problems, academic achievement, adolescent pregnancy, incarceration and self-esteem, which are prevalent problems among Latinos in the United States and Latin American countries, suggesting that school-based SFBT interventions may have wider applicability if translated and adapted to Latin American countries.

LIMITATIONS OF THE SYSTEMATIC REVIEW

One limitation of this review is that is possible that every study was not found across the Latin American countries where academic resources and search engines may not be well developed, however, a thorough search of published and non-published literature was undertaken in both English and Spanish so the authors are confident that the review is representative of the current literature. Another limitation of this review was the inclusion of studies that combined SFBT with other therapeutic approaches because it is more difficult to determine the efficacy of the SFBT approach with the Latino populations. The combining of therapeutic approaches, however, appeared to be a common trend in the study of SFBT with Latinos making it important to include combined studies. In addition, the studies were developed in a variety of practice settings with diverse samples ranging from children to older adults and this makes it difficult to determine the effectiveness of SFBT with particular problem areas or age groups. This limitation of SFBT research has been previously noted and this current review reinforces

the need to build on the effectiveness of SFBT with a specific groups and problems (Franklin et al., 2012). The studies on Latinos were skewed also toward females with 91% of the participants being females. This may be partly due to the studies on adolescent pregnancy that were almost exclusively Latina and the studies in primary care where women often participate more than men, however, it limits the conclusions that can be drawn. The research designs had other limitations such small sample sizes and design flaws. Many studies would only qualify as small pilot studies that need further replications with better research designs before definitive conclusions can be drawn about the effectiveness of SFBT with Latinos. Nevertheless, these results reflect the state of the research on SFBT with Latinos and compliment other reviews in the field.

CONCLUSIONS

Solution-focused brief therapy originated among English-speaking therapists and its translation to other languages such as Spanish is at an early stage of development. This review suggests SFBT is applicable among Latino populations and that there is an increasing interest in its use in Latin America. SFBT has been studied in small RCT's and quasi-experiments with Latinos in the United States and in Latin America, however, the studies are not developed to the point of drawing any definitive conclusions about its' effectiveness with different problems or age groups. The studies reviewed here show mostly positive but some mixed results in Latin America with adults who have mental health symptomology and with older adults with psychosocial and mental health concerns. In the United States, the studies reviewed show positive outcomes with

children in schools with behavior and emotional problems, academic failure and self-esteem. Across studies SFBT has been applied with both individual and group interventions and this review indicated that SFBT interventions were extremely brief with an average of only three individual sessions and of six-point-five group sessions. Finally, the individual interventions were in behavioral health practice setting while the other applications used a group modality across populations including children, adolescents, and adults.

Chapter 3:

Solution-Focused Brief Therapy for Chilean Primary Care Patients: Exploring a Linguistic Adaptation

INTRODUCTION

Solution-focused Brief Therapy (SFBT) is a contemporary resource-based therapeutic approach that is present- and future-oriented and focuses on solutions rather than problems (Bavelas et al., 2013). The core characteristics of SFBT are observing previous solutions, looking for exceptions, questions versus directives or interpretations, compliments, and gentle nudging to do more of what is working (Bavelas et al., 2013). In terms of the length of treatment, the therapist states at the very beginning of the process that the intervention will continue until the client decides it is no longer needed (De Jong & Berg, 2012, Bavelas et al., 2013, De Shazer, 1985). Research suggests that SFBT intervention usually runs from four to six sessions (Corcoran & Pillai, 2009; Gingerich & Peterson, 2013). This approach has been applied across several populations including school children, older adults, couples, and individuals with mental health conditions (e.g., de Schazer & Isebaert, 2004; Gingerich & Peterson, 2013; Kim & Franklin, 2009; Naude, 1999; Schmit, Schmit & Lenz, 2016). Among individuals with mental health issues, SFBT has been effective in those presenting alcohol-use disorders, and has demonstrated effects on controlled alcohol use or abstinence up to four years after treatment (De Shazer & Isebaert, 2004; Hendrick, Isebaert & Dolan, 2012; Kim, Brook & Akin, 2016; National Registry of Evidence-based Programs and Practice 2012; Polk, 1996; Smock et al., 2008). SFBT has also been effective for internalizing disorders such as anxiety and depression,

which are closely associated with alcohol use (Carrera et al, 2015; Gingerich & Peterson, 2013; Kim, 2008; Schmit et al., 2016). Accordingly, individuals receiving treatment for alcohol-use disorders also show diminished depressive symptoms after receiving SFBT (Smock et al., 2008).

SFBT has also been used among diverse racial/ethnic groups in the United States (Franklin & Montgomery, 2013) and around the world, including Latin American, Spanish, Chinese, German, and Italian populations (Beyebach, Sánchez, de Miguel, Herrero de Vega, Hernández, & Rodriguez, 2000; Burr, 1993; Kim, Franklin, Zhang, Liu, & Qu, 2015; Schade, Beyebach, Torres & González, 2009, Ulivi, 2000). The application of SFBT to Spanish-speaking populations has most certainly required some cultural or at least linguistic adaptations, such as translation and implementation by practitioners of the same cultural background. However, among outcome studies on SFBT with Latinos and Latin Americans, none of the published studies delineates the adaptation process or the specific adaptations that researchers made (Gonzalez, Franklin & Kim, 2016). Therefore, the current study attempts to address the limitations of previous research by developing a linguistic adaptation of the main SFBT tools for a Chilean primary-care population. This linguistic adaptation will inform practitioners in Chile regarding the terminology and expressions to use when practicing SFBT with a clinical population.

Program adaptation of brief interventions

Program adaptation is a modification of the components, delivery, or cultural aspects of an intervention based on its target community (Backer, 2002). Castro, Barrera,

and Martinez (2004) observed a constant mismatch between the population with which interventions have been validated and the actual consumers of those interventions, such as language of the implementation (e.g., English versus Spanish), the target racial/ethnic group (e.g., Whites versus Latinos or African Americans), staff (e.g., culturally competent versus culturally insensitive), and socioeconomic status (e.g., median-high income versus low income). Practitioners who work with diverse target populations might consider such factors when implementing interventions. The term *cultural adaptation* refers to certain intervention modifications that implementers make in order to address potential clients' backgrounds, traditions, values, and beliefs (Kumpfer, Alvarado, Smith, Bellamy, 2002). Resnicow, Soler, Braithwaite, Ahluwalia, & Butler (2000) suggested two dimensions along which to adapt interventions. The first dimension, surface structure, corresponds to observable social and behavioral characteristics in the target population culture. Examples of surface structure among alcohol users would be the type of beverages they drink, the names of the drinks, and other vocabulary employed by drinkers when referring to drinking situations (e.g., being drunk, heavy drinking). Resnicow and colleagues (2000) have also compared this dimension to the face validity of an intervention, and may include community participation during the intervention-design stage. The second dimension of a cultural adaptation refers to the associations among specific cultural, social, psychological, environmental, and historical factors inherent to a cultural group and its health behaviors (Resnicow et al., 2000). For instance, alcohol-use disorders (AUDs) are associated with

biopsychosocial determinants that are interconnected (International Center for Alcohol Policies, 2009). However, those associations may vary across cultures and racial/ethnic groups.

Castro, Barrera and Holleran-Steiker (2010) established four circumstances relevant to an intervention or target population that may indicate a need to conduct a cultural adaptation. These conditions are unsuccessful engagement, unique risk or resilience factors, unique symptom presentations, and decreased efficacy of an intervention among a specific group. This suggests that a comprehensive cultural-adaptation process may be premature without knowledge of the efficacy of the original intervention with that target population. However, when the intervention has been developed in a language other than the one in which it will be implemented, it is reasonable to consider some surface adaptations (Castro et al., 2010), such as translation and linguistic adaptation.

Barrera, Castro, Strycker, and Toobert (2013) proposed a five-stage model to conduct cultural adaptations of psychosocial interventions. Stage One involves information-gathering, such as searching for evidence of cultural elements that influence risk factors and that researchers might target for modification. This stage also includes gathering information from potential recipients, implementers, and other stakeholders who make suggestions for possible changes to the original intervention. Stage Two is the preliminary adaptation design, which consists of translation and back-translation of the intervention materials, the integration of suggestions made by those who took part in

Stage One, the preservation of core elements, and the corroboration of preliminary materials with potential participants and community stakeholders. Stage Three consists of preliminary adaptation tests such as staff training, pilot studies, and information-gathering on the main difficulties, satisfaction aspects, and suggestions for improvements. Stage Four involves adaptation refinement, which is mainly the incorporation of feedback gathered in the Stage Three. Finally, Stage Five consists of conducting a randomized controlled trial of the refined culturally-adapted intervention (Barrera et al., 2013). This paper addresses Stages One and Two.

The importance of SFBT

Several countries in Latin America have established routine implementation of brief behavioral interventions for alcohol use in primary care (e.g., Chile, Dominican Republic, Panama, Venezuela; World Health Organization, 2010). SFBTs for AUDs may be an additional powerful tool for helping decrease the public health burden of alcohol-related disease and death in Latin American countries such as Chile. The use of SFBT in such contexts may additionally affect conditions comorbid with AUD, such as depression and anxiety, which are common in primary care. We believe that SFBT is transferable to Chileans with alcohol-use disorders for several reasons. First, there is evidence to support SFBT effectiveness with alcohol-use disorders in the U.S. and Europe (De Shazer & Isebaert, 2004; Hendrick, Isebaert & Dolan, 2012; Kim, Brook & Akin, 2016; National Registry of Evidence-based Programs and Practice 2012; Polk, 1996; Smock et al., 2008). Second, the main SFBT intervention skills foster collaborative relationships, respect for

the background and culture of the clients, and an interactional context, which are consistent with aspects of the Latino culture such as *personalismo*, *familismo*, and *respeto* (Corcoran, 2000; Oliver & McNichols, 2011). Third, empirical research reports implementations of the model with Latin Americans and Latinos in the U.S. (Cordero, Cordero, Natera & Caraveo, 2009; Gonzalez, Franklin & Kim, 2016). However, we assert that SFBT would benefit from a cultural-adaptation process at the surface level to ensure linguistic appropriateness and acceptability, and a basic consideration of general cultural aspects related to alcohol use in the Chilean population that accesses primary care. Despite the current use of SFBT among Spanish-speaking populations, no published report of any cultural adaptation of SFBT exists to the best of our knowledge.

METHOD

The methodology that guided the process of inquiry in this study reflects the model suggested by Barrera and colleagues (2013) and corresponds to the first and second stages for cultural adaptation of evidence-based interventions. These two stages consist of a series of activities to begin to develop an intervention that is culturally sensitive to the needs and preferences of a Chilean, primary care patients. The approach in this project is derived from the social constructionist perspective and involves inquiring about meanings and individuals' experiences. The social constructionist perspective differs from the positivist perspective and implies that knowledge is historical and produced collectively by society, and that it is constantly changing, because

"meanings are constructed by human beings as they engage with the world they are interpreting" (Crotty, 1998, p. 43).

Participants

Participants in the current study were adult consumers of primary care services of Santiago, Chile located in an underserved neighborhood of about 20,000 inhabitants. Inclusion criteria specified that participants for individual and focus-group interviews were: 1) between 18 and 65 years of age, 2) resided in a town south of Santiago, Chile, 3) had at least one heavy alcohol-use episode in the past year, 4) displayed no impediment to verbal communication with others, 5) answered "yes" to the question, "Have you gone to a social worker or psychologist in the past?" 6) and answered "yes" to the question, "Have you ever had four or more alcoholic drinks on one occasion during the past year?" Twenty-one individuals (11 women and 10 men) participated in the three focus groups, and nine individuals participated in the interviews.

Recruitment

We recruited participants for this study through two main strategies: First, community leaders helped locate volunteers to take part in focus groups and interviews. Second, we used snowball-sampling. Thus, when a participant knew of somebody who was interested in participating, the researcher encouraged them to invite the potential participant to the interview or focus group.

Participants completed a written informed-consent at the beginning of the interview and focus group process. No financial compensation was offered for any of the

activities. Snacks and non-alcoholic beverages were provided at the meetings. This study was submitted for review and deemed exempt by the Institutional Review Board of The University of Texas at Austin.

Procedures

The data-collection method consisted of nine individual cognitive interviews and three focus groups. All interviews and focus groups were audio-recorded on a digital recorder and then transcribed. Since we conducted interviews and focus groups in Spanish, we transcribed and analyzed them in Spanish. Both the interview guide and the focus-group guide were designed specifically for this project. The individual interviews obtained information to adapt the core interventions of a SFBT approach to the culture of alcohol-consuming individuals in Santiago, Chile. The methodology employed in the interviews was cognitive interviewing (Beatty & Willis, 2007), which has been used to develop interviews and interventions in the health field (e.g., Carbone, Campbell, & Honess-Morreale, 2002; Muroff et al., 2014). Cognitive interviews consist of asking the interviewees about the understandings and emotions that emerge when they are faced with certain information (Carbone, Campbell, & Honess-Morreale, 2002), which in this case were SFBT tools. In addition, during this type of interview, the interviewer requests feedback to clarify the questions for a more comprehensive understanding (Carbone et al., 2002). We modified and adapted SFBT tools to Chilean clients in response to the feedback provided by participants in cognitive interviews. Then, two independent, bilingual graduate students who have worked in social services in Chile and understood

the sense of the questions in both languages back-translated the questions. They reviewed a list of questions in English and Spanish and provided feedback regarding how questions in Spanish reflected the meaning of questions stated in English.

The focus-group interview consists of provoking a group conversation in which participants are encouraged to state their opinions freely regarding a topic (Kvale & Brinkmann, 2009). We conducted three focus groups (one with men only, one with women only, and one combined group) to examine the main cultural aspects related to alcohol-use disorders in Chile, including questions about the typical drinks consumed, places in which alcohol is used, the amount of alcohol consumed, the acceptability of alcohol-use across genders, age groups, and contexts, support network for individuals with drinking problems, and aspects to consider in a brief treatment.

Data Analysis Plan

We analyzed the interview and focus-group data using a content-analysis method. Content analysis aims to reach a conceptual description of a determined phenomenon (Elo & Kyngas, 2008). In this case, the researcher followed a deductive or directive approach of content analysis, because the purpose was to test hypotheses, guided by theoretical assumptions regarding the issues related to the interventions of SFBT and alcohol use (Elo & Kyngas, 2008; Hsie & Shannon, 2005). The results of the interview analysis served as feedback regarding what kind of language is the most effective in the implementation of SFBT tools and whether there is any change or exclusion needed in this linguistic adaptation. In addition, the results of the focus groups analysis gave

insight into drinkers' perceptions of their context and culture, which complemented the linguistic adaptation. However, since SFBT practitioners hold a "not-knowing stance," this information will only inform the research and practitioners with context and realities of each client.

To generate trustworthiness in the study, we employed three methods. First, the process of data analysis included the peer-review technique, where both the PI and a collaborator trained in qualitative analysis analyzed the interviews and focus groups (Creswell, 2012). Second, the PI developed an audit trail in order to keep the process of research accountable (Rodgers and Cowles, 1993). Third, the long-term relationship that the PI had with this community ensured a prolonged engagement with participants, which allowed her to build trust with participants, have knowledge of the culture, and check for any potential distortion during the interviews (Creswell, 2012).

RESULTS

The first goal of this study was to translate and linguistically adapt a solution-focused intervention looking specifically at the usual interview questions. Individual cognitive interviews were carried out to obtain feedback from the participants in terms of the linguistic appropriateness of seven specific interventions mentioned in the SFBT manual (Bavelas et al, 2013; i.e., pre-session change, future-oriented questions, solution-focused goals, scaling questions, coping questions, exception questions, and experiment suggestion). The second goal of this study was to compile drinking experiences and cultural aspects related to drinking, such as the contexts and occasions on which people

drink, differences across genders and generations, consequences of drinking, and issues to include in brief treatments for drinkers.

Linguistic adaptation

In the first part of the study, the interviewer stated the questions to check how understandable they were to the interviewee; then, the interviewer immediately asked what the interviewee understood that question to mean. There were cases in which interviewees responded as if they had been asked the question and gave examples of their possible answers to the stated question. This was considered proof that the interviewee had indeed understood the question. For example,

Researcher: What things have been better in your life since you were scheduled for this appointment with me?

Participant: That question sounds to me… like what has been going on from that period to now.

Researcher: Do you understand that I am asking you what things have been better?

Participant: Things that have been better?

Researcher: Do you understand clearly, or shall I ask it another way? Because what I want to know is that, sure, since they gave you the appointment until now, in that period, is what things in your life have been better?

Participant: What things in my life have been better? My mood…

Researcher: Ah, but I am asking if that was clear to you or not…

Participant: Oh no! Yes! Yes… yes! I understand you…

This example reflects a process in which interviewer and interviewee find a "common ground," consisting of coordinated actions performed in a conversation to reach mutual understanding (Clark, 1996). In accordance with the common-ground process, there are times in which the recipient in a conversation misinterprets what the communicator intends to express; these are misunderstandings occur in normal conversation all the time (Sayer, 2013). Misunderstanding and understanding as well as the creation of meaning are part of dialogic actions performed during conversations (Sayer, 2013) and due to the theoretical and empirical foundations of SFBT, these communication processes fit perfectly with the therapeutic conversations that occur in SFBT. During the cognitive interviews, some participants misunderstood the interview's logic or found the questions of SFBT specific techniques difficult to understand. In that case, the researcher changed strategies and asked the participant to imagine that he or she had instead come to an appointment with a social worker. The interviewer asked participants to imagine that they had a problem and to respond as if they were in the session. Making this change did not negatively affect the goal of the interviews, but rather helped both the researcher and the interviewee find a "common ground" to better understand each other (Clark, 1996; De Jong et al, 2013). As a result, the interviewees gave responses that were consistent with the question. For example,

Researcher: What things related to the issue you came here about (he had decided to represent a man with alcohol problems) have improved between the time you

scheduled the appointment with me and now? Is there anything that has improved?

Participant: Yes, for example, the… change of life of… the ability to see things in another… another way because with the alcohol you see them distinctly.

Table 1 summarizes the adaptations that we made to the SFBT questions based on the interviews. Below is a description of how we obtained these changes.

Pre-session Change

Weiner-Davis, de Schazer, and Gingerich (1987) reported the pre-session change question as an "accidental discovery" draws clients out to state any change related to the issue that brought them to therapy before beginning their sessions. The interviewee stated the question about the pre-session change to participants as follows: "What things have been better in your life since you scheduled the appointment to come see me?" Participants provided varied feedback to this question. Four out of nine participants understood the question immediately, and five did not understand it as it was stated. Among these five, three participants did not make sense of the question. For example, one stated an example of answer that did not match the question and another asked why things should be better if they had not yet received any help. Two participants helped build a very similar question that included a new piece (in italics) that clarified the original version: "What things *related to the issue you came here about* have improved/been better since you scheduled/they gave you the appointment with me?"

Asking for exceptions

Asking for exceptions is a type of solution-building question that frames the notion that "problems are discontinuous realities because they are not always present in clients' lives," and clients have already experienced their own solutions (Miller & de Shazer, 1998, p. 7). In this sense, exceptions constitute time periods when clients would have expected the problem to have presented itself, but it did not (de Shazer, 1985). In this study, the participants were asked "Have there been times in which you felt you were at least a little bit better?" All nine participants understood the question clearly, and the following questions were the most useful to explore the details of exceptions: "What did you do to make it better?" "How do you notice that things are better?"

Scaling

This type of question invites individuals to make an assessment of their situation and to rate it on a scale from 0 to 10 or 1 to 10, as shown in the literature (i.e., De Jong & Berg, 2013, Pichot & Smock, 2009). Since this question may be asked around different issues, such as motivation, confidence, or goals (De Jong & Berg, 2013), the researcher chose to check whether the number logic worked in Chilean culture by asking the question in terms of a change or goal: "On a scale of 1 to 10, with 10 being where you want to be, your goal, and 1 is the worst you can imagine, what level are you at now?" Seven out of nine participants understood this question as stated originally and two of them provided feedback to make it clearer in a generic way: "If I told you that you have to choose a number between 1 and 10, where 10 is that no problem exists, and 1 is the worst that could happen, what number are you at right now?" Another way suggested for

stating this question was: “Let´s think of a scale from 1 to 10, where 10 is a life without problems, and 1 is the worst you could be. What number *do you find* yourself at today?”

Coping

Coping-questions represent one way to implement compliments, one of the main interventions that SFBT promotes (Bavelas et al., 2013), and at the same time are consistent with the strengths-based perspective. The main goal of a compliment is “to help the client discover his own resources and strengths he did not know that he had” (Berg, 1994, p 112). De Jong and Berg (2012) called coping-questions “indirect compliments” since they did not compliment the clients directly but through a question that clients would likely answer in a way that would help them realize their strengths. Scaling-questions provide a direct opportunity to ask coping-questions. For example, after a scaling-question, the therapist may ask how individuals have managed their situations to make it to this number. The interviewer presented the question as follows: “How do you know/notice/realize that you are at this level and not lower?” Eight out of nine interviewees asked the interviewer to reformulate this question. From the suggested reformulations, the version most easily understood by participants was “What are you doing or /have you done to be at that number and not lower? In this sense, asking people to think of what they *did* facilitated the comprehension of the question. One interviewee stated the number “one” as an answer. In this case, the researcher constructed several questions. The best-understood question was “How have you been living your life in a

way that has allowed you to come here and not be worse? Despite everything, you got out of bed, got dressed, and walked here today… how did you do it?"

Relationship questions

As De Jong and Berg (2013) assert, relationship-questions elicit descriptions of interactional situations in which clients create meaning and subsequent solutions. This question refers to what differences significant-others perceive in the client, in real or hypothetical situations. The interviewer stated four relationship-questions as complements to the exception questions. The first relationship-question was "Who may notice that things are better?" All nine participants found this question to be clear. The second question was "What do they see in you that let them know you are better?" All participants found this question understandable.

Two relationship-questions were stated in relation to scaling-questions, and participants were able of make sense of them. One question was "What level of the scale would they say that you are at today?" While all participants understood this question well, two of them suggested a very similar version: "What level of the scale *do you believe* that other people would say you are at? After this initial question related to the scale from 1 to 10, another question was asked in order to obtain a detailed description of the current status and how others may see the situation: "Why do you think they would say that you are at that number?" This question did not require modification, as all nine participants comprehended the original version.

Future-oriented questions

Developing well-formed goals is one of the main strategies employed to build solutions by eliciting clients to formulate in concrete terms what they want (De Jong & Berg, 2013). To this end, the practitioner formulates future-oriented questions, aligned with the principle that "the therapeutic focus should be on the client's desired future rather than on past problems or current conflicts" (Bavelas et al., 2013). In this sense, the aim is to help clients to "identify how they would like their lives to be despite the current presence of their problems" (Pichot & Smock, 2009). These questions referred to the end-of-session, 24-hour question, long-term future or a time-when-the-problem-no-longer-exists question, and fast- forward question (Pichot, 2015, personal communication). Pichot & Smock suggest that practitioners who are new to the model should not employ the miracle question, which is a future oriented question. Therefore, that question was not included among future-oriented questions in this study.

The *end-of-session question* originally asked was "Imagine that it is the end of this session, and you go home with the sensation that this conversation we had today was useful. How do you know or in where do you notice that the session was useful?" Eight out of nine participants found this original version understandable and only one suggested a simpler version of the second part of the question: "How would you realize that this conversation had been worthwhile?"

The *24-hour question* is a future-oriented question that helps individuals with concrete examples of how they can advance towards their desired future (Pichot, 2015, personal communication). The original question was stated as follows: "What would be

one thing you could do in the next 24 hours that would improve your chances of getting to a better number on the scale we have been talking about?" All nine participants modified this question. Eight out of nine agreed that the "improve the chances" piece was difficult to understand and could not elaborate on its meaning. Thus, six participants helped to reformulate the question into "What could be a thing you do/could do in the next 24 hours to help you get better/move forward?" Two participants agreed on "Think of something you could do between now to tomorrow that would help you get to that score you want." One participant did not understand the question and gave an example of answer that was unrealistic: She had a daughter with special needs and her example was "I would like my daughter to get well."

The interviewer stated the following *long-term question*: "How would you like things in your life to be when the problem that brought you here no longer exists?" Four out of nine participants understood the question as it was originally stated. Another group of four participants preferred the question without the "in your life" piece: "How would you like things to be when the problem does not exist?" One participant could not make sense of the question, arguing that she would expect the practitioner to give her a solution. This same participant could not figure out how things could be better when asking the pre-session change question.

The *fast-forward question* is a future-oriented question that seeks to help clients to envision their progress at a future point by forming solution-focused goals. In this study, the interviewer initially asked participants to look ahead a week: "Imagine that we travel

into the future one week, this is seven days from today, and things are better. At what number on the scale we have been talking about will you be?" Eight out of nine participants agreed on a very similar version of this question: "Imagine we travel to one week from now and things are better. At what number of the scale that we have talked would you be located?" For one participant, it was hard to understand the sense of the question; thus, the interviewer asked to pretend that he was a client and reformulated the question into "If things were a little bit better in one week, what number on the scale would you be at?" Then the participant was able to formulate an answer.

Homework and Experiments

When conducting SFBT, the therapist typically closes the session by formulating a final message to the individual or family (Bavelas et al., 2013). DeJong and Berg (2013) assert that the end-of-session feedback is usually provided after a "thinking-break" and builds on exceptions and solutions that the clients have mentioned during the session. De Schazer and colleagues (1986) proposed a structure for this message that consists of a set of compliments, a bridge, and a task or suggestion for clients. The interviewer initially presented the suggestion component of the end-of-session feedback to participants as a homework assignment called First-session Formula-Task: "I want to ask that between now and the next session, you pay attention to the little things that would help you progress towards the place you want to be in the future, when the problem no longer exists." All participants asked the interviewer to repeat the entire sentence, stating that they could not understand the question. Five out of nine participants understood

reformulations of this intervention. The reformulations that participants better understood were four, the first was: “I want to ask that from now to next week you to pay attention to the small things that help you be / get better, and notice what you do.” The second was “Between now and next week, I want you to notice what things you do that help you move forward, and do those things again. When you realize that you have done something that worked out well, repeat those actions.” The third was “When you see things get better, please make a note of what you did to move from the number that you mentioned you are, towards the ideal number.” The fourth was “I want to ask you that from now on, you see what works out well when things are better, and then keep doing that.” The other four participants did not understand the sense of the suggestion as they tried to replay the sentence as if the interviewer were asking them to think of an immediate response.

Intervention	Original question *Spanish version in italics*	Modified question *Spanish version in italics*
Pre-session change	What things have been better in your life since you scheduled the appointment to come to see me?	What things *related to the issue you came here about* have improved/been better since you scheduled/they gave you the appointment with me?
	¿Qué cosas han estado mejor en su vida desde que te dieron la hora para venir a verme?	*¿Qué cosas han mejorado/ estado mejor en su vida, respecto de este problema que lo trajo acá, desde que le dieron la hora hasta hoy día?*
Exceptions	Have there been times in which you felt you were better/ at least a little bit better? If so, how did you manage to be better?	--- "What did you do to make it better?" "How do you notice that things are better?If so, how did you do it to be better?
	¿Ha habido veces en que sientes que estuviste mejor/al menos un poquito mejor? Si es así, ¿cómo lo manejaste para estar mejor?	--- *Si es así, ¿Cómo lo hiciste para estar mejor? ¿Cómo se da cuenta que las cosas están mejor?*
Scaling	On a scale of 1 to 10, with 10 being where you want to be, your goal, and 1 is the worst you can imagine, what level are you at now?	On a scale of 1 to 10, with 10 being where you want to be, your goal, and 1 is the worst you can imagine, what level are you at now? If I told you that you had to choose a number between 1 and 10, where 10 is that no problem exists at all and 1 is the worst thing that could happen, what number are you at right now? Let´s think of a scale from 1 to 10 where 10 is life without any problems and 1 is the worst you could be, what number do you find yourself at today?
	En una escala de 1 a 10 donde 10 es donde tú quieres llegar, tu meta, y 1 es lo peor que imaginas que puedas estar, ¿en qué nivel te encuentras hoy?	*En una escala de 1 a 10, donde 10 es donde usted quiere estar, su objetivo, y 1 es lo peor que puede imaginar ¿en qué nivel está ahora?* *Si yo le dijera que tiene que elegir un numero entre 1 y 10, donde 10 es que no existe ningún problema y 1 es lo peor que podría pasar ¿en qué número está hoy?* *Pensemos en una escala de 1 a 10 donde 10 es la vida sin problemas y 1 es lo peor que podría estar ¿en qué número se encuentra hoy día?*

Table 3: Record of Change in SFBT Interventions in English and Spanish

Intervention	Original question *Spanish version in italics*	Modified question *Spanish version in italics*
Coping	How do you know/notice/realize that you are at this level and not lower?	What are you doing or /have you done to be at that number and not lower?
	¿Cómo sabes/ en que notas/ como te das cuenta/ que estás en ese número y no más bajo/peor?	*¿Cómo lo hace/como lo ha hecho usted para estar en ese número y no más bajo?*
Relationship question	Who may notice that things are better?	---
	¿Quién podría notar (quien se daría cuenta) que las cosas están mejor?	---
Relationship question	What level of the scale would they say that you are at today?	What level on the scale *do you believe* that other people would say you are at?
	¿En qué número/nivel de la escala dirían ellos que tú estás hoy?	*¿En qué nivel de la escala cree usted que las otras personas dirían que usted está?*
Relationship question	Why do you think they would say that you are at that number?	---
	¿Por qué crees tú que ellos dirían que estas en ese nivel?	---
Relationship question	What do they see in you that let them know you are better?	---
	¿Qué es lo que esta persona ve en ti que te ubica en este nivel y no en un nivel más bajo o peor?	---
Fast-forward	Imagine that we travel into the future one week later, this is seven days from today, and things are better, at what number on the scale we have been talking about will you be?	Imagine that we travel to one week from now and things are better, at what number on the scale that we have been using would you be? If things were a little bit better a week from now, at what number would you be?
	Imagine que viajamos al futuro, a una semana después, es decir, viajamos siete días desde hoy (decir el día) y las cosas están mejor, ¿en qué número de esa escala que hemos estado hablando se encontrarás?	*Imagínese que viajamos a una semana después […] y las cosas están mejor ¿en qué número de la escala que hemos conversado se pondría usted?* *[…] Si estuvieran un poquito mejor las cosas de aquí a una semana, ¿en qué número estaría usted?*

Table 3, cont.

Intervention	Original question *Spanish version in italics*	Modified question *Spanish version in italics*
Long-term	"How would you like things to be in your life when the problem that brought you here does not exists? *Cómo le gustaría que fueran las cosas cuando el problema que lo trajo aquí ya no exista?*	How would you like things to be when the problem does not exist? *¿Cómo le gustaría que fueran las cosas cuando el problema no exista?*
End of session	Imagine that is the end of this session and you go home with the sensation that this conversation that we had today was useful, how do you know or in what do you notice that the session was useful? *Imagínese que es el final de la sesión y usted se va a su casa con la sensación de que esta conversación que tuvimos hoy fue útil, como sabe usted/en que nota que la sesión fue útil?*	Imagine that we are at the end of the session and you go home with the sensation that this conversation was useful, *how would you realize that this conversation had been worthwhile?* *Imagínese que estamos al final de la sesión y usted se va a su casa con la sensación que esta conversación fue útil, como nota que fue útil?*
24 hours	What would be one thing you could do in the next 24 hours that would improve the chances of getting to a better number on the scale we have been talking about? *¿Qué podría ser una cosa que usted pudiera hacer en las próximas 24 horas que mejorarían las posibilidades de que usted logre estar en un mejor número en la escala (o en una mejor situación) que hemos estado hablando?*	Think of something you could do from now until tomorrow that would help you to move toward that score you want. What could be a thing you do/could do in the next 24 hours to help you get better/move forward? *Piense en una cosa que usted podría hacer de aquí a mañana que le ayudaría en avanzar hacia ese xx que usted quiere.* *¿Qué podría ser una cosa que usted haga, dentro de las próximas 24 horas, que le ayude a estar mejor/avanzar?*

Table 3, cont.

Intervention	Original question *Spanish version in italics*	Modified question *Spanish version in italics*
Homework assignments	I want to ask you that from now to the next session you pay attention to the little things that would help you to progress towards this future place you want to be when the problem does not exist	I want to ask you that from now until next week you pay attention to the small things that help you to be better and notice what you are doing. From now until next week, I want you to notice the things you do that help you to move forward on the scale and repeat those actions. When you realize that something happened and worked out well and you repeat those actions. When you see that things are going better, you focus your attention on what you did to go from the number xx you mentioned that you are at right now towards the ideal number. I want to ask you that from now on, you see what works well when things are better and then repeat those over again.
	Quiero pedirle que de aquí a la próxima sesión ponga atención en las pequeñas cosas que le ayudarán a avanzar hacia ese lugar o imagen que usted tiene de cuando el problema ya no esté.	*Le voy a pedir que de aquí a la próxima semana, usted se fije en las pequeñas cosas que la ayuden a estar mejor y se fije en lo que usted hace.* *De aquí a una semana, quiero que se fije en las cosas que usted hace y que le ayudan a avanzar en esa escala y las repita.* *Cuando se da cuenta que algo pasa y que eso funcionó y repita esas acciones.* *Cuando vea que las cosas van mejor, usted se fije que es lo que hizo usted que le sirva para avanzar desde el xx número que usted me dijo que está ahora hacia el número ideal.* *Quiero pedirle que aquí en adelante usted vea lo que funcione bien cuando las cosas estén mejor y después las haga de nuevo.*

Table 3, cont.

Intervention	P1	P2	P3	P4	P5	P6	P7	P8	P9	Freq
Pre session change	1	1	1	1	1	-	-	-	-	5
Exception	-	-	-	-	-	-	-	-	-	0
Scaling	1	-	-	1	-	-	-	-	-	2
Coping	1	1	1	1	1	-	1	1	1	8
Relationship 1	-	-	-	-	-	-	-	-	-	0
Relationship 2	-	-	-	-	-	-	-	-	-	0
Relationship 3	-	-	1	1	-	-	-	-	-	2
Relationship 4	-	-	-	-	-	-	-	-	-	0
End of session	-	-	-	-	1	-	-	-	-	1
24 hours	1	1	1	1	1	1	1	1	1	9
Long term	1	1	1	1	-	-	-	1	-	5
Fast forward	-	-	-	-	1	-	-	-	-	1
Homework	1	1	1	1	1	1	1	1	1	9
Total questions changed	**6**	**5**	**6**	**7**	**6**	**2**	**3**	**4**	**3**	
Never understood a question	1	1	3	1	2	-	1	-	-	9

Note: P1 to P9 = participant 1 to participant 9; Relationship 1 = Who may notice that things are better?; Relationship 2 =What does he/she see in you that let him/her know you are better?; Relationship 3 = At what level of the scale do you believe that other people would say you are?; Relationship 4 = Why do you think they would say that you are at that number?

Table 4: Frequency of change of interventions by participant.

The analysis of SFBT interventions examined in this study showed that out of thirteen interventions, all participants understood only four as originally stated (exceptions and three relationship questions). All other nine interventions required changes by at least one participant. Only one participant required a change in the future-oriented end-of-session questions and fast-forward questions; two participants changed the scaling question and one relationship question; five participants changed the pre-session and the long-term questions; eight participants changed the coping question; and finally, all participants changed the 24-hour question and the first session formula task. Nevertheless, there were four questions which some participants were unable to make sense of, despite the changes

and alternatives of questions stated by the interviewer. They were the cases of pre-session change (three participants); 24-hour (one participant), long-term (one participant), and first formula task (four participants). Nevertheless, we decided to keep these questions in the model because most of participants did understand them. However, further observation and exploration of the usefulness of these questions that adapt SFBT to Latin American populations is recommended. In addition, all participants changed anywhere from two to seven questions, and five out of nine changed more than five questions. The frequency with which participants did not make sense of questions varies. One did not understand three questions, one did not understand two questions and four did not understand only one question (see Table 2). It is interesting that these are past- and future-oriented interventions, suggesting that practitioners should be cautious when implementing these type of questions to Chileans. In the next section we will review some cultural aspects that drinkers associate with alcohol and that complement the linguistic adaptation of SFBT techniques presented in this section.

Alcohol use in Chileans

Several issues emerged from the focus-group analysis: culturally-prescriptive norms; acceptance and morality attributed to alcohol use across genders; alcohol use and community contexts; alcohol use and family; additional participants in treatment besides the drinker; and types of treatment that may help individuals. We present these findings below.

Culturally-prescriptive norms

Participants stated that men drink more than women and, usually, women drink lighter and sweeter drinks than do men. For example: "Men like harder drinks and women like lighter ones… beer, for example, men like … rum the most." However, they acknowledge that these differences have decreased over generations, that younger women drink more than older women do, and that the difference in the amount of alcohol consumed between genders has diminished. For example:

"Nowadays more 14- or 15-year old girls are drinking than before… but in the past you did not see that, there were more men drinkers than women, women were more reserved."

Acceptance and morality attributed to alcohol use across genders

In spite of similarities in alcohol use across genders in younger generations, it was observed that for Chilean men and women, it looks bad (*mal visto*) when women drink excessively, and worse if they do so in public. This view contrasts with the values about men drinking. For example, "A drunk woman is… ugly, in contrast, a drunk man is like normal. It´s more common. That´s the word!" or, "I feel sad when I see a woman. I try to help. If it´s a man, I don't care." In these statements, participants affirmed that drunkenness in men is accepted and even expected by the community, while in women, it is not pleasant nor tolerated.

Alcohol use and the community context

When asking participants about their alcohol providers, they all agreed that they would purchase alcohol at alcohol shops located in the neighborhood. However, when these formal stores are closed, there are underground places called *picadas* that sell alcohol. Typically, men are the ones who purchase alcohol at *picadas*. In relation to where they

drink, participants stated that men can drink in several places, but that women should not drink in outdoor areas such as parks. In this sense, there is a wide agreement that people should not drink in certain places and situations such as a church, while driving, at work, in front of children, and at a hospital.

Alcohol Use and Family

The role of family in alcohol use appeared several times in the focus groups. Drinking in the family is found in the context of celebrations, parties, or festivities. Family is even a "safe environment." It is considered preferable for people to drink at home where they are protected from potential injury and assault, as opposed to public places such as discotheques, pubs, or outside. A family member's drinking negatively impacts the family. Interviewees affirmed that drunk individuals become aggressive and are very likely to cause hard feelings and other types of damage at home. For example: "[When I drink], it messes up the whole family, because drinking makes me aggressive and the next day I don't remember anything I did. My family is very affected by it." Family is a source of support when people want or need to stop drinking, and female figures have an essential role in helping people seek help and get better. Although support figures may be male, when asked who would be there to help when you need it, the universal answer was *la mamá;* some people mentioned their wife, a daughter, or another woman in the family. For example, "*la mamá* is the one who has the influence, because you do not realize what you are getting into. *La mamá* is always concerned." In addition to women, participants noted that the love of their family helped them change:

> In my case, it happened like this: I fell, hit the ground, and was taken to the hospital. When I got home, my kids started talking to me and caressing me and telling me how much they loved me… and that helped me change.

Participants agreed that family may not be helpful in cases in which delinquency or other risk factors contribute to increased alcohol use instead of recovery. In this sense, SFBT practitioners, following an ecological approach (Pichot & Smosk, 2009), should focus on strengths and resources available in extended family, relatives, or other family members that serve as potential support for individuals in treatment. In addition, participants suggested other potential sources of support besides the family. This is discussed in the next section.

Who may participate in treatment besides the drinker?

Although this point is related to the previous one in that most people stated that family should be included in treatment, it became a new theme, as loved-ones should be present even if they are not family members. For example, "[…] sometimes if they have no family, even a loved-one who is an important support can be..." In this sense, close friends and neighbors are important in these processes too. For example, "If they have no relatives, they can have the support of a friend, or a neighbor who commits to help in therapy.

What type of treatment may help individuals?

When participants were asked what to include in therapy for excessive alcohol-users, some responded that the social worker should ask and talk about topics important to the drinker, such as his family: "The social worker, when talking with the drinker who drives could show them (a picture of his) family because they have a family, too, so they believe

that he is a family person […]" or the issues that bring them to therapy: "the reason why he wants to participate." This viewpoint is very consistent with the SFBT approach that emphasizes "beginning where the client is" and closely following what that client wants as a method for building a solution with the client.

Another issue that participants mentioned was coordination among the various branches of the health care system. That is, it is important for a client to know that all of his health care providers coordinate and communicate with each other. For example, "The health care system must participate, too so that they know what is going on," or "working in conjunction with the Mental Health Center." The coordination approach is closely aligned with SFBT because SFBT develops collaborative relationships between clients and other systems.

These topics provide important insights for practitioners who apply the SFBT model in Chile. Even when SFBT encourages the practitioner to adopt a not-knowing stance regarding family members or significant loved-ones, asking about who and what is important to the client, and providing well-assisted referrals to other levels of mental health services, echo the spirit of SFBT and brief interventions for alcohol use in primary health care. In addition, the acceptance of drinking and the prescriptive norms attributed to alcohol use help to clarify differences between the men and women social workers will treat, providing a general scenario that also supports the statistical information available at this time.

DISCUSSION

This paper reports the results of a study that will inform the implementation of SFBT interventions for a clinical population in Chile. This study used qualitative methods to linguistically adapt SFBT questions such as pre-session change, future-oriented questions, solution-focused goals, scaling questions, coping questions, exception questions, and homework and experiment suggestions as well as gathering experiences and cultural aspects of alcohol use among Chilean individuals. Results of this study support the importance of translating interventions based on culture (Castro et al., 2004; Cross et al., 1989; Kumpfer et al., 2002; Resnicow, 2000). Interviewees understood a minority of SFBT questions outright. Therefore, participants made several suggestions for specific wording that could enhance the understanding of the majority of the questions. Generally, participants proposed simplifying questions and phrasing (e.g., using fewer and / or simpler words, avoiding repetition, or attempts to explain the questions). This suggests that small variations to the questions, based on each client, will help clients understand the question better. This is supported by research on microanalysis that shows the process of grounding in which clients and therapists find a common ground using words and phrases that both parties construct in session (De Jong et al., 2013). A common adaptation that fits the SFBT approach is the use of connectors such as "Let's think of…," "imagine that…," or "if I told you that…" These connectors led the interviewees to a question and might be useful in gaining the attention of the client in order to find a common ground.

An interesting issue related to the use of the language was that individuals preferred the verb "do" (*hacer*) instead of other verbs such as "notice" or "manage" for coping questions. This might be related to the use of Spanish in which the expression "how did you

do it?" (*¿como lo hizo?)* is commonly employed to ask about coping. In this sense, practitioners implementing coping questions for Spanish-language speakers should formulate them in terms of how individuals *did* things despite the problem.

Four areas of questioning were not understood by some interviewees, Pre-session change, future-oriented questions, 24 hour and long-term questions, and the First-Session Formula Task, thus requiring substantial revisions to these questions. In relation to Pre-session change question, which is an unusual question participants may have not been predisposed to think that change can occur before receiving assistance. This suggests that this question might benefit from an introduction such as "sometimes people take action before coming to the social worker…" which may help people make sense of the question. Nevertheless, prior studies state that when asked about pre-session change, more than sixty percent of those asked, reported changes (Lawson, 1994; Reuterlov et al., 2000; Weiner-Davis, de Shazer, & Gingerich, 1987). This percentage implies that about forty percent of people either reported no change or made no sense of the question. However, when changes did occur, they were associated with the success of the therapy process (O'Hanlon & Weiner-Davis, 1989). Since quite a large percentage do report change prior to starting therapy, and the fact that this early effect may contribute to the therapy's success, this intervention is highly recommended. Future studies involving Latinos should explore the associations between responses to pre-session change and change processes experienced throughout therapy.

Participants reported struggles in understanding three questions: 24-hour, long-term, and first-session formula task. These all address future situations. It is possible that interviewees were not familiar with future-oriented questions and were at a loss to make

sense of them. Another potential explanation in two participants (one man and one woman), who had repeated difficulty understanding questions and could not make sense of two and three questions out of thirteen, may be due to some cognitive impairment or cultural deprivation. Nevertheless, other participants also changed questions that these two participants needed to change, and in fact, these two participants did understand most of questions (about 80% of them) so they may represent a small proportion of clients for whom some questions may not work. These findings are far from discouraging and suggest a word of caution when stating future-oriented questions that put the clients in uncertain or challenging situations such as "what could happen between now and tomorrow?" or "imagine that the problem does not exist," which ask them to think about a response which requires a commitment on their part. Again, as most of participants in this study did understand future-oriented questions, the suggestion is to continue practicing the interventions, being cautious when prompting situations that imply a greater commitment or challenge to clients. Future studies with Latinos and Latin Americans should explore the diverse responses and effects of asking various future-oriented questions in the therapy processes.

This study further researched cultural aspects related to the use of alcohol within the Chilean population such as norms, availability, activities, and sources of support, so that practitioners could consider these aspects when providing SFBT in Chilean primary care. We highlight three main issues to consider in providing treatment. First, there is a strong stigmatization regarding the use of alcohol by women, the strongest for older women. SFBT addresses this type of issues by promoting that practitioners keep a collegial, positive, and solution-focused stance, which allows for an empathetic attitude toward

clients. SFBT may be especially helpful because of its strengths-oriented and non-pathologizing stance toward clients and its focus on building competencies and solutions instead of problems. Practitioners working with women should be especially supportive and empathetic toward feelings of shame, blame, and stigma that they may bring to sessions. In addition, externalizing the problem of alcohol use with women may be a useful technique to work on de-stigmatization. This technique consists of using language that separates the problem from the individual (e.g., the problem of alcohol instead of your alcoholism) and was originally developed by narrative therapists (White & Epston, 1980). It also has been adapted for use in SFBT and may be useful in externalization when working with women. Second, participants stated that including significant others (*seres queridos*) would have a positive impact on the treatment. These people are not necessarily family members, and may be friends, neighbors, or relatives. SFBT can be practiced in individual, family, or group formats. In fact, evidence is emerging that group SFBT is more effective than individual SFBT. These findings are also consistent with SFBT's relational roots within brief family therapy (Schmit, Schmit & Lenz, 2016). Even when clients start individual treatment, they are usually willing to ask someone who plays an important role in their life to take part in the therapy with them, if their practitioner suggests this. This approach is consistent with the social-constructionist and relational approach of SFBT because both problems and solutions are viewed as being constructed and deconstructed within conversations and interactions between people. SFBT is respectful of Latino relationship patterns such as *familismo* and *personalismo* (Corcoran, 2000; Oliver, Flamez, & McNichols, 2011) This respect for relationship patterns evolved from a brief family therapy, meaning that no change is needed in the intervention format (de Shazer, 1982).

Third, participants mentioned that social workers providing treatment should ask clients about what is important to them, *La familia* being the one most mentioned. As stated, SFBT authors constantly listen for what the clients want in order to find what is meaningful to them (e.g., DeJong & Berg, 2012; Bavelas et al., 2013; Pichot & Smock, 2008). This approach complements the process of listening for exceptions or solutions, selecting them, and building and amplifying them with questions and responses that help clients create their own solutions (Bavelas et al., 2013). Again, practitioners should invite *la familia* and any other close relationships to participate in treatment when clients believe that they may make a meaningful contribution. Since this last aspect is in harmony with the SFBT approach, we do not recommend further changes in this area.

Even though this study was specific to Chile, it is the first study that examines a linguistic adaptation of SFBT to Spanish speakers in Latin America and may be useful to others who work with alcohol users in Latin America especially within primary care settings. Primary care is the prototypical setting for treating AUD, not only in Chile but in other Latin American countries as well (World Health Organization, 2010). This study may also help to inform SFBT implementation with newly immigrant populations to the U.S. because of the Spanish translation into and the suggested improvements to the SFBT questioning methods that may enhance the understanding of the SFBT intervention. Future studies will test this intervention in primary care settings within Chile. Additionally, studies from various other Latin American countries and within US with newly immigrant populations may build on the findings of this study.

LIMITATIONS

This study followed a qualitative methodology, seeking to generate trustworthiness and meanings from the participants, who were key informants regarding the understandability of SFBT questions and the experiences of drinking alcohol. Even when the process of translation and back-translation to a Chilean Spanish was conducted by Chilean and bilingual collaborators, a limitation of this translation was that these bilingual collaborators were highly- educated people. Future studies should include individuals with lower education levels and diverse backgrounds. We developed the study with an urban population from southern, low-income towns in Santiago, Chile; thus, its results may not be representative of middle- or high-income or rural populations. However, as we state in the discussion section, the similarities with other authors in terms of the features that Latino populations present, argue for the possibility that the findings of this study represent other populations in Chile and other Spanish-speaking Latin American countries.

CONCLUSION

This is the first linguistic adaptation of the Solution-focused Brief Therapy for Latino individuals with AUD. The goal of this study was to conduct a linguistic adaptation of the major SFBT questions and to collect data on the cultural aspects of alcohol use among Chileans. After incorporating changes suggested by interviewees, all participants understood nine out of thirteen interventions completely, suggesting that Chilean clients may comprehend the approach of SFBT. In terms of alcohol use cultural aspects, stigmatization towards women who drink, the inclusion of significant others and *la familia*, and asking clients for what is important to them are the main themes that should be

addressed by practitioners when implementing the approach. All these issues are manageable keeping the core elements of SFBT.

Chapter 4:

Solution-Focused Brief Therapy for Individuals with Alcohol Use Disorders in Chile: A Pilot Study

INTRODUCTION

Alcohol use disorders (AUDs) are a major public health problem in the world that is associated with a reduced life expectancy, mental health conditions, familial and social problems, and are also a direct cause of death (Rehm & Monteiro, 2005; World Health Organization, 2014). Chile reports the highest average amount of alcohol consumption in the Americas, citing the highest percentage of population with AUDs (8.5%). This has resulted in serious health consequences, namely the highest alcohol attributable fraction to cirrhosis among Latin American countries, which was 66.3% for men and 66.9% for women who have the disease (World Health Organization, 2014, 2015). In addition, the proportion of the Chilean population whose deaths were wholly attributable to alcohol use was almost two times greater (9.8%) than the proportion of the worldwide population that met that indicator (5.9%; Castillo-Carniglia, Kaufman & Pino, 2013; World Health Organization, 2014). Mental health conditions, such as anxiety, depression and social problems like domestic partner violence, are also frequently associated with AUDs. This is true among both adolescent and adult populations in Chile, (Basso Musso, Mann, Strike, Brands, & Khenti, 2012; Toledo, Pizarro, & Castillo-Carniglia, 2015; Rojas et al., 2012; Vizcarra, Cortez, Bustos, Alarcon, & Munoz, 2001a & 2001b) pointing to a need for behavioral health interventions that can address co-morbid AUDs and mental health conditions.

In response to the pervasive use of alcohol and its associated problems, Chile created a National Alcohol Policy. Consequently, in 2006, the Chilean Ministry of Health launched a program to provide alcohol and drug treatment for individuals who werearrested for non-criminal offenses (e.g., driving under the influence, neighborhood disturbance, family violence) as a complement or alternative to punishment (Ministerio de Salud de Chile, 2006). In 2007, Law N^{o} 19,966 established "Explicit Health Guarantees," which stipulate that private and public health insurance companies must provide quality coverage that is accessible, timely and that covers 69 diseases, including AUDs (Ministerio de Salud de Chile, 2013). In addition, this Law mandated that the Alcohol Use Disorders Identification Test (AUDIT) be applied in the primary care setting and be part of the screening for alcohol use. The expectations are that this measure will be used to identify individuals that can be provided with brief interventions (BIs) (Ministerio de Salud de Chile, 2010). In 2010, fifty percent of individuals with mild to moderate AUDs were treated in primary care settings with some type of BI (Minoletti, Rojas, & Horvitz-Lennon, 2012), which underscores the importance of developing culturally relevant and effective BIs that can be implemented in primary care settings.

Brief interventions for alcohol use disorders in primary care

Every indication is that BIs are effective and have potential for use in high demand settings, such as primary care, because they allow practitioners to implement effective interventions that are low cost in terms of time and resources (Substance Abuse and Mental Health Services Administration, 2012). For example, one review of 29 studies on BIs in primary care settings showed similar outcomes in alcohol consumption when compared to extended interventions (Kaner et al., 2007). Other studies have also shown that, in different

settings and countries, BIs have had significant effects on drinking-related outcomes, measured up to 12 months after the intervention (Bien et al., 1993; Bertholet, Daeppen, Wietlisbach, Fleming, & Burnand, 2005; Moyer et al., 2002; Vasilaki, Hosier, & Cox, 2006). Specifically, SFBT was found to be efficacious for patients with AUDs (mild to severe; Hendrick et al., 2012) and with Level 1 alcohol users with comorbid depressive symptoms (Smock et al., 2008). Different ranges of AUDs and depressive comorbid symptoms are common among patients treated within Chilean primary care settings (Minoletti et al., 2012). None of the BI studies mentioned, however, were conducted in Chile, despite the recommendations by the Ministry of Health to universally implement BIs in primary care.

There is a definite need to implement and study BIs for AUDs in primary care settings in Chile. This need is driven by the pervasiveness of AUDs, policy and program mandates, and the practicalities of addressing behavioral health disorders within primary care. In addition, BIs can be used by different health care professionals, and promising research indicates that BIs in primary care are effective and that their implementation remained effective regardless of the health provider that delivered the BI (O'Donnell et al., 2014; Sullivan, Tetrault, Braithwaite, Turner, & Fiellin, 2011). In this vein, Cochran & Field (2013) suggested that social workers could play key roles in the implementation of BIs in the primary care settings. In order to prepare social workers for these roles within primary care in Chile, decisions need to be made on what BIs to implement and study, since these practitioners may implement several different types of BIs for AUDs. We believe that in Chile, BIs for AUDs also need to include a relational approach (e.g., mental health and family dynamics), because in Latin America, and specifically in Chile, there is an important

association between alcohol use and these factors (Gonzalez, Franklin, Cornejo, Castro, & Jordan, 2016). For this reason, this study examines the implementation and outcomes for a linguistically adapted, SFBT intervention in primary care, as this particular BI focuses on social interactions, mental health conditions, and solution-building, and it has been shown in other studies to be effective in addressing depression, anxiety and family problems (Gingerich & Peterson, 2013; Kim, 2008; Kim, Brook, & Askin, 2016; Kim, Franklin, Zhang, Liu, Qu & Chen, 2015; Schmit, Schmit, & Lenz, 2016; Smock et.al. 2008).

Linguistically adapted solution-focused brief interventions (SFBI)

Even though BIs for AUDs have been implemented within diverse ethnic/racial groups and countries, (e.g., Botvin, Schinke, Epstein, Diaz, & Botvin, 1995; Field, Caetano, Harris, Frankowski, & Roudsari, 2010; Rodriguez-Martos et al., 2005; de Shazer & Isebaert, 2003) most of research has not reported results disaggregated by race. This includes the solution-focused brief therapy (SFBT) (O'Donnell et al., 2014; Franklin & Montgomery, 2013). Culturally adapted interventions with Latinos have been shown to be more effective than those that are not culturally adapted, suggesting that SFBT may also benefit from linguistic and other cultural adaptations (Field & Caetano, 2010; Lee et al., 2013). In this regard, no specific studies on SFBT with AUD have been reported in Chile, suggesting that a minimum linguistic adaptation and subsequent study are warranted.

One RCT on SFBT that was implemented in Chile was with patients presenting somatoform symptoms, and this study showed effectiveness in symptom reduction, service utilization, and medical expense reduction (Schade, Torres, & Beyebach, 20011). The results of this SFBT study suggest that SFBT can be effectively applied to mental health conditions. In addition, SFBT has been implemented in Mexico (another Spanish-speaking

Latin American country) with AUDs (Cordero, Cordero, Natera, & Caraveo, 2009). Among this study's findings were that individuals with lower incomes and more severe AUDs had better outcomes, and that individuals who sought to modify problems associated to alcohol use were more likely to remain abstinent and to actually modify their alcohol-related problems than clients who wanted to modify their drinking patterns (Cordero et al., 2009). None of these studies reported a linguistic or cultural adaptation of SFBT to either Chilean or Mexican culture, indicating that modifications may be warranted for future studies that are conducted with Spanish speaking populations.

SFBT researchers suggest that the approach is consistent with the notions of *familismo* and *personalismo* because SFBT considers an interpersonal context and relies on cooperation (Corcoran, 2000; Oliver & McNichols, 2011). A recently conducted study on the linguistic adaptation of SFBT to the Chilean population suggests that individuals value the inclusion of significant others in treatment for AUDs (Gonzalez et al., 2016). SFBT targets not only individuals' behaviors but also their interactions with their family members and other systems. SFBT helps clients reach alcohol-related goals differently from traditional treatments. The therapist's role is to assist clients in building their own solutions by assessing their own goals, analyzing their past experiences, and discovering what works for stopping or diminishing drinking (de Shazer & Isebaert, 2003; Pichot & Smock, 2009). This process often involves the clients' realization that their solution involves much more than stopping or reducing their drinking, and that their goal should also include the enhancement of other aspects of their lives (de Shazer & Isebaert, 2003; Pichot & Smock, 2009).

Rationale for the study

AUDs are serious health and social problems in Chile and are likely to co-occur with mental conditions such as depression and anxiety disorders; they can also result in family problems, such as domestic violence and child abuse. For these reasons, it is important for BIs for alcohol use to be able to treat depressive and anxiety symptoms as well as family relationships. SFBT is a mental health intervention that has shown promise in impacting alcohol use, mental health conditions and family relationships, and it harmonizes with the notions of *familismo* and *personalismo* that characterize Latino culture (Corcoran, 2000; Oliver & McNichols, 2011). The SFBT intervention can also be applied within primary care. To the best of our knowledge, there are no linguistic adaptations of SFBT that have been implemented for alcohol use disorders in Latin America. Therefore, this study presents a pilot test of a linguistically adapted SFBT that is delivered by social workers in a primary care setting. The linguistic adaptation of SFBT has been reported elsewhere, (Gonzalez et al., 2016) and the focus of this present study is to examine to what extent Chilean social workers are able to adhere to the SFBT intervention and to further investigate the outcomes as they relate to alcohol risk and usage, and depression and mental wellbeing. Examining the applicability of a linguistically adapted SFBT by Chilean social workers will set the basis for the effectiveness of SFBT in primary care with AUDs and for further research on its efficacy and comparisons with other interventions such as MI or CBT. We hypothesized that social workers would welcome and be able to adhere to the SFBT approach. In addition, we expected that, after the SFBT intervention, individuals would improve their alcohol use patterns and other factors associated to alcohol use, such as consequences of alcohol, depression, self-reported wellbeing, and family relationships.

METHOD

The purpose of this study was to conduct a pilot test of the linguistic adaptation of solution-focused brief therapy (SFBT) by social workers who received training in this BI. The target population of the intervention was low-income individuals who used alcohol and who received primary care. To that end, five social workers received a 30-hour training in SFBT. Each social worker implemented SFBT with two clients while receiving direct supervision of their work.

Procedures

Linguistic Adaptation

The official manual of The Solution-Focused Brief Therapy Association (Bavelas et al., 2013) was translated into Spanish by the PI and subsequently reviewed and edited by a Chilean psychologist who is an expert in SFBT. The manual was further back translated by another professional social worker. This material was complemented by other literature related to the development of SFBT in Latin America and Spain (e.g. Beyebach, 2013; Schade et al., 2011). In addition, each of the interventions detailed in the manual (e.g., asking for exceptions, coping questions, scaling questions, future oriented questions) were supplemented with the linguistically adapted questions that were formulated in a previous stage of the study (Gonzalez et al., 2016). These linguistically adapted questions were written in Spanish based on cognitive interviews conducted with Chilean individuals and then were back-translated to English by two social workers who are native English speakers and who are also fluent in Chilean Spanish. After this process, the list of questions in English was reviewed by two SFBT expert researchers who validated them as being consistent with the approach. These materials are available from the main author.

Training

Social workers received 30 hours of training consisting of five 4-hour sessions (20 hours), which consisted of an exhaustive review of the translated manual, other complementary materials of SFBT such as videos of Insoo Kim Berg, and role playing practice and analysis. In addition to that, social workers received 10 hours of direct supervision in their work place. The trainer was an MSW and PhD student, who was an advanced practitioner with 10 years of clinical practice in primary care settings and with underserved families, and who received training in Solution-Focused Brief Therapy leading to the International Solution-Focused Practitioner Certificate.

Intervention

Eight patients with alcohol use disorders (AUD) received three individual sessions of SFBT. Sessions lasted between 30 and 60 minutes and consisted of therapeutic encounters between a social worker and a patient. We designed a protocol (available from the first author) for each session, including the main techniques of SFBT, scale questions, relationship questions, a break, compliments, and first-session formula-task (Bavelas et al., 2013). These interventions were previously linguistically adapted to Chilean culture and reported elsewhere (Gonzalez et al., 2016). Towards the end of each session, social workers took a break to summarize strengths and useful information regarding the strategies that the client has already developed to provide a solution-focused feedback to the client and a suggestion (or homework) that usually consists of doing more of what works or observing when exceptions occur. First and subsequent sessions had the same structure. However, the second and third session included what has worked well, specifically during the period between the last session and the current, and enhancing the exceptions and strategies that

will help the client to reach his/her desired future. At the end of the third session, the social worker and the client will complete a certificate stating that the client has successfully participated in the treatment. The certificate had a written statement in which the client acknowledged his/her strengths and exceptions that will help him/her to advance toward the solution.

Research Design

This study used a single-case AB design with eight replications. Single-case designs are experimental, time-series designs where the unit of intervention and data analysis is an individual case (a participant or a group of participants) and the comparisons are different measures applied to the case at different stages of the intervention to observe changes in the dependent variable (Kratochwill et al., 2010). Specifically, the AB design that is used in this study is frequently used in practice evaluation and is appropriate for applied settings where randomization and the withholding of treatments are not possible. The design is quasi-experimental and relies on multiple replications to show that clients are progressing in treatment after the introduction of an intervention. As such, our research team applied the same measures to 8 participants on repeated occasions with the aim to measure the case at the baseline, during intervention, and post-intervention (Kratochwill et al, 2010; Rubin & Babbie, 2014. This study provided opportunities to study the implementation and outcomes of a linguistically adapted SFBT intervention and provides the groundwork for future RCT studies (Bloom, Fischer, & Orme, 2009).

All eight participants had a baseline period during which they were consulted on three occasions regarding their alcohol use during the last period. After the two-week baseline period, all participants received the same intervention (three SFBT sessions). As

such, the plan considered three observations for the baseline, two observations during the intervention, and one observation one month after the end of the intervention. To check for fidelity of the implementation of the SFBT approach, we audio- and/or video-taped the sessions and analyzed them with the Solution-Focused Fidelity Instrument (Lehmann & Patton, 2012). This instrument was translated into Spanish by the PI and back-translated to English with the collaboration of two bilingual social workers whose native language is English and whose second language is Chilean Spanish.

Participants

Study participants were recruited through three strategies: referrals from medical or paramedical personnel who detected any AUD as measured by the AUDIT (part of the preventive examination undertaken regularly in the clinic); self-referrals from people in the community who heard of the research project through flyers, and signboards; or from referrals from a third party that told them about the project. Study participants received compensation of 3,000 Chilean pesos (about $5 USD) for coming to the clinic to fill out the measures forms. The target population was men and women, ages 18 years and above, who were patients at two clinics in southeast Santiago, and who were identified as presenting any alcohol use disorder as measured by the AUDIT. To participate in this study, individuals had to be between 18 and 65 years of age, able to verbally communicate with others, willing to participate in the intervention, and willing to fill out measures forms. Individuals were excluded if they presented a severe and untreated mental illness such as schizophrenia. Each time a patient was referred, the PI called the potential participant for a meeting to invite him/her to the project. The potential participants received information

about the project and were advised of their rights. Additionally, participants signed a written Informed Consent.

Measures

Background information. Age, gender, relationship status, educational attainment, income, and job status will be observed at baseline.

Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST; Humeniuk & Ali 2010). This is an 8-item questionnaire developed by the World Health Organization that aims to detect at-risk substance use and predict low, moderate, and high risks due to substance use in primary care settings. These classifications mirror the substance use disorders continuum towards which the DSM-5 and the ICD-11 are trending (Humeniuk & Ali, 2010). For moderate AUDs, the sensitivity was 83% and the specificity was 79%, and for severe AUD the sensitivity was 67% and the specificity was 60% (Humeniuk et al., 2008; Humeniuk & Ali, 2010). The validation in Chile (n=400) was developed in several settings such as primary care, policy stations, and working places (Soto-Brandt et al., 2014). In terms of convergent and discriminant validity, the cut-off points that provided the best level of sensitivity and specificity were ≥ 11 for moderate risk (sensitivity 86%; specificity 78%) and ≥ 21 for high risk (sensitivity 81%; specificity 54%). This screening instrument was used to measure high-risk alcohol use in participants before and after the intervention because this is the instrument employed in the first trial of brief interventions for substance users in Chile. Therefore, using this measure will result in comparable outcomes. This instrument was administered at the baseline and at one-month follow-up.

Timeline Follow-Back (TLFB; Sobell & Sobell, 1992). This is a self-reporting tool to observe the quantity and frequency of consumption. It consists of a calendar to record clients' quantity and frequency of alcohol consumption during the prior week. Several variables can be calculated from the information gathered by the TLFB, namely, maximum amount of drinks in one day, average drinks per week, total amount of drinks in the past week, percentage of days abstinent, and number of times/days of heavy drinking. The TLFB has been validated with several populations in several settings and modalities (Sobell, Brown, Leo, & Sobell, 1996; Sobell et al., 2001). It was also validated in Mexico, using the validity criterion of comparing the TLFB to a self-monitoring measure of quantity and frequency (Annis et al., 1996). Intra-class correlations were higher than .90 for total number of drinks, number of drinks per drinking days, number of days with one to four drinks, number of days of heavy drinking, and number of abstinent days (Sobell et al., 2001). For interpreting the TLFB, the cut points are defined in relation to patterns of alcohol use that determine at-risk alcohol use, heavy drinking episodes, and their frequency, or other patterns that researchers define depending on the setting. For example, Ayala and colleagues (1995, 1997, 1998) categorized drinking patterns according to the number of drinks consumed in one occasion (low = 1-4 drinks, moderate = 5-9 drinks, and excessive = 10 or more drinks). This instrument was employed at the baseline and at one month follow up to create a re-constructed record based on the client memory. In addition to this tool, a calendar to record the daily alcohol use was provided to participants to be completed during treatment.

Patient Health Questionnaire (PHQ-9). This is a self-administered instrument that was designed to be employed in primary care settings and corresponds to the depression module of PRIME-MD, a tool for identifying several mental health disorders (Kroenke, Spitzer, & Williams, 2001). The tool reflects the nine depression symptoms of the DSM IV and has been found to have high convergent validity (r=.73; P<.0001) with the short version of the Beck Depression Inventory when detecting depression severity (Martin, Rief, Klaiberg, & Braehler, 2006). The PHQ-9 has been translated into Spanish and validated in Chile with adult populations (Baader et al., 2012). In Chile, the convergent validity of the PHQ-9 was measured against the Hamilton Depression Rating Scale with 88% of sensitivity (major depression) and 92% of specificity (no depression; Baader et al., 2012). This instrument was administered at the baseline, at the beginning of treatment, two weeks after the beginning of treatment, and at a one-month follow-up.

Family Health (Salud Familiar; SALUFAM). This is a 13-item screening instrument that was developed by a Chilean team using questions from several instruments and that assesses familial aspects such as agreement, cohesiveness, emotional expressions, conflict, commitment, trust, social support, labor stressors, familial stressors, and health stressors (Püschel, Repeto, Solar, Soto, & Gonzalez, 2012). The final version of the instrument contains the dimensions of "agreement" and "family support". Answers range from "never" =1 to "always" =5. The SALUFAM was found to be efficacious in terms of predicting health vulnerability associated with familial risk. The cut point was established at 3.7 points wherein families receiving scores ≤ 3.7 reflect lower agreement and family support, which suggests higher health vulnerability (Püschel et al., 2012). This instrument was administered at the baseline and at one-month follow-up.

Short Inventory of Problems (SIP; Miller, Tonigan, & Longabaugh, 1995). This is a short 15-item instrument that derived from a longer instrument named DrInC. It includes five dimensions of alcohol-related consequences. The correlations between the SIP and the DrInC were $r \geq .80$ and accounted for 92% of the variance that these two scales shared (Forcehimes et al., 2007). Recently, a Spanish version was validated among Latinos in the United States who were injured and received emergency medical care (Marra, Field, Caetano & von Sternberg, 2014). Through a confirmatory factor analysis, the study found that the English version (with Caucasian and Latino samples) and the Spanish version (with a Latino sample) were equivalent in terms of reliability and construct validity (Marra et al., 2014). They reported an internal consistency of $\alpha = .94$ for the Spanish language version and similar values for the other versions as well; and the factor loading for the 15 items varied from .51 to .81, in the Spanish language version (Marra et al., 2014). Authors also found that the English and Spanish version had strict factor invariance, which means that the two versions are comparable in terms of each of their items (Marra et al., 2014). This instrument has not been normed and can be interpreted as higher scores indicating higher severity or in terms of amount of consequences reported (higher number suggesting higher severity). The SIP was administered at the baseline and at one-month follow-up.

Outcome Rating Scale (ORS). This 4-item self-reporting measure gathers information about three areas, specifically, individual, interpersonal and social, and also contains an overall wellbeing score. The ORS was designed as an alternative to a longer instrument called the Outcome Questionnaire (45 items). The internal consistency was over .90 and test-re-test reliability were higher than .80 (Bringhurst, Watson, Miller & Duncan, 2004). The ORS has been validated with clinical populations, demonstrating positive variation after

psychotherapy (Miller, Duncan, Brawn, Sparks, & Claud, 2003). It was translated to Spanish and tested in Chile with an internal consistency of .78 and a content validity through an expert panel (Cantuarias, Mahaluf, & Sepúlveda, 2009). This instrument was applied at the beginning of each session and served to establish therapeutic goals and challenges in each area.

Solution-Focused Fidelity Instrument. We provided a 30-hour training to four social workers, each of whom implemented three sessions of solution-focused brief therapy to two patients. Sessions were audio-taped and/or observed through a one-way mirror. To check for fidelity of the implementation of the SFBT approach by trained social workers, the interventions were audio-recorded and analyzed by the PI and independently by another practitioner that was an expert in SFBT. To this end, the translated version of the Solution-Focused Fidelity Instrument (Lehmann & Patton, 2012) was employed. This is a 13-item tool that asks for thirteen specific SFBT interventions. This instrument was reviewed in accordance to the prior linguistic adaptation of the approach in order to maintain consistency and coherence among the language aspects, the manual, training delivered to social workers, and the evaluation of its fidelity.

Measures were administered in a private room by the PI or a trained research assistant. The implementation of baseline measures lasted an hour, on average, whereas measures in the second, third, fourth and fifth observations took 15 to 30 minutes. The follow-up interview took about 45 minutes (See Table 5).

MEASURES	APPLICATION TIME	PHASE A			PHASE B		
		W 1	**W 2**	**W 3**	**W 4**	**W6**	**W10**
Background	5 min	X					
ASSIST	5-15 min	X					X
TLFB	10-20 min	X	X	X	X	X	X
PHQ-9	5-10 min	X			X	X	X
SALUFAM	5-10 min	X					X
SIP	5-10 min	X					X
ORS	2 min	X	X	X	X	X	X

Table 5: Measure Administration by Phase

Interviews

After the intervention was complete, social workers were interviewed individually to gather their feedback regarding the applicability of the SFBT approach with the Chilean population in primary care settings. This interview followed a semi-structured format that consisted of reviewing each of the interventions contained in the manual and discussing whether some changes or suggestions to improve the model should be done for future interventions.

Analysis Plan

Fidelity and perceptions of social workers

Implementation of SFBT by social workers will be examined with descriptive analyses that inform regarding their level of adherence to the treatment techniques across sessions, settings and practitioners. In this regard, we observed the frequency with which the social workers adhered to the items during each session and the frequency with which they employed each technique. This information was complemented with a content analysis of the social workers' interviews that were conducted with the social workers who implemented the model. The goal of the content analysis followed a deductive or directive

approach since it was focused on examining a specific and pre-determined issue—the applicability of SFBT interventions (Elo & Kyngas, 2008; Hsieh & Shannon, 2005).

Descriptive analysis

To analyze participants' demographic information and baseline reports of outcome variables, we conducted descriptive analyses and also included participants who dropped out of the intervention. We also ran T-test and Chi square analysis in order to explore any significant differences between participants who completed the treatment and participants who dropped out.

Visual analysis

We examined outcome measures applied in the six observations—percentage of days abstinent, average of alcohol use during the last period, maximum amount of drinks during the last period, and outcome rating scale—following a visual analysis across all subjects, to observe their trends at baseline, intervention, and follow-up phases (Kratochwill et al., 2010).

Percentage of Non-Overlapping Data (PND)

We also conducted PND analysis to examine the efficacy of the program on the outcome variables "percentage of days abstinent," "average of alcohol use during the last period," "maximum amount of drinks during the last period," "outcome rating scale," and "depressive symptoms." PND is a commonly employed non-overlap method in which we observed "the percentage of Phase B data exceeding the single highest Phase A data point" (Parker, Vannest & Davis, 2011). Since Phase B had only three observations, the calculated

PND can only result in 0%, 33%, 67%, or 100%. Thus, the results must be interpreted considering these restrictions.

Linear Regression

We conducted linear regression analyses on the outcome variables "family health," "consequences of alcohol use," and "alcohol use risk level," since these variables were measured only on two occasions, at the baseline and one month following the intervention. Thus, we used a dummy variable indicating Phase B, which allowed the identification of the average variation of each outcome variable that could be associated to the intervention. To manage dispersion among results across participants between phases A and B, we reported robust standard errors to heteroscedasticity (Angrist & Pischke, 2009).

Multilevel analysis

Researchers in the field of educational psychology have elevated the discussion regarding how to analyze and synthetize data from single case designs (e.g., Moeyaert, Ferron, Beretvas & Van den Noortgate, 2014; Davis et al., 2013, Parker, Vannest & Davis, 2011) since visual analysis and common non-overlapping models fail to statistically represent the results of several participants. In the past, some authors have suggested utilizing meta-analysis methods (Parker et al.), whereas more recently, researchers have innovatively proposed to synthetize single case designs results following multilevel analysis (Moeyaert et al.; Davis et al.). Thus, we conducted a multilevel analysis in order to obtain a quantitative estimation of the association between the intervention and the interest outcome variables "percentage of days abstinent," "average of alcohol use," "maximum of drinks in one day," "perception of wellbeing," and "depressive symptoms." We analyzed

data of individuals who completed the treatment and also completed a supplementary analysis including participants who did not complete the intervention (dropouts), detailed in the next section. We modeled the mentioned outcome variables into two levels. The first level corresponds to each observation per subject (six, if the subject completed the treatment), and the second level corresponds to the participants. For example, in the analyses including only participants who completed the treatment, the first level involved 48 observations, which is eight (participants) multiplied by six (observations); and the second level corresponded to the eight participants. Although some authors also suggest modeling the temporal auto-correlation of errors (Moeyaert et al., 2014), Shadish (2014) asserts that when employing models with random effects, as is the case of this study, there is no need to conduct this procedure to control for the occurrence of Type 1 Error. We explored two models of multilevel analysis. The first model presented by Moeyaert and colleagues (2014), corresponding to *Model 1a,* presents a regression equation Y_{IJ} in which the outcome score on alcohol use pattern or self-reported wellbeing for subject J at observation I (e.g., percent of days abstinent at a particular moment J) is regressed on an intercept indicating baseline phase β_{0J} (e.g., average percent of days abstinent in Phase A) and a coefficient associated to the intervention phase $\beta_{1j}PhaseB$ (e.g., average percent of days abstinent in Phase B) both considered random effects as they vary across participants. Thus, our Model 1 at the first level examining the observations was:

$$Y_{ij} = \beta_{0j} + \beta_{1j}PhaseB + e_{ij}. \quad (1)$$

The second level of Model 1 examining the participants was:

$$\beta_{0j} = \theta_{00} + u_{0j}.$$

$$\beta_{1j} = \theta_{10} + u_{1j}. \quad (2)$$

As such, the reduced model was:

$$Y_{ij} = \theta_{00} + \theta_{10}PhaseB + u_{0j} + u_{1j} + e_{ij}. \quad (3)$$

In this model, the fixed effect θ_{00} corresponds to the average alcohol use variable during Phase A, whereas θ_{10} corresponds to the average change of outcomes at Phase B (intervention). Similarly, u_{0j} indicates the variation of each subject at baseline whereas u_{1j} indicates the variation of each subject's response to the intervention, and e_{ij} corresponds to the estimated error of each observation nested in the subjects. In addition, we estimated the correlation between u_{0j} and u_{1j}.

Model 2 included the same elements than Model 1 plus a temporal variable $\boldsymbol{\theta_{20}}$ that corresponds to the number of days passed between each observation. Thus, the reduced model was:

$$Y_{IJ} = \theta_{00} + \theta_{10}FaseB + \boldsymbol{\theta_{20}Time} + u_{0j} + u_{1j} + e_{ij}.$$

(4)

Supplementary analysis of dropouts

Therapy drop-out is not uncommon and is especially high when interventions are studied under real world conditions. There are many reasons that a client may leave a therapy prematurely, including client and therapist characteristics and elements of the intervention. There are also many possibilities for the outcomes achieved by those clients during their exposure to the therapy. SFBT does not assume that a dropout or non-completer of a course of therapy is treatment failure. The SFBT approach is collaborative and promotes the self-determination of the client. It offers a theoretically different way to

think about clients that leave therapy (Bavelas et al., 2013). One of the key elements of SFBT, for example, is to invite the client to think of what needs to happen so that they do not need therapy anymore (De Jong & Berg, 2013). It is feasible that a client may decide to stop coming to therapy because they have reached their goals, meaning that a client that is considered a dropout may actually show positive changes. Following this approach to understanding dropouts, it is important to explore whether outcome variables also changed among participants who dropped out from the three-session program and whether including them in the analysis would affect the results. Since multilevel methods allow for weighing the cases, we conducted a supplementary analysis including all 15 subjects that participated in the study and explored the effects of treatment on outcome variables considering the available data.

RESULTS

Recruitment and Participants

Sixteen patients in two primary clinics located in southern Santiago, Chile were invited to participate, fifteen of those agreed to participate, nine finished the treatment and eight completed all the measures. Four social workers were trained in SFBT between January and April, 2016 and implemented the program between April and July 2016. As shown in Table 3, participants who completed the intervention were, on average, 14 years older, had a lower monthly wage by 150 dollars, and reported lower education attainment than individuals who dropped out of the treatment. In addition, one fourth of participants who completed the treatment were women, whereas the individuals who dropped out were all men.

Fidelity of the intervention

It was not possible to analyze four out of 24 sessions due to technical problems in recording the sessions. All other 20 sessions were supervised via one-way mirrors, audio- or video-recorded, or both. As Table 6 shows, 10 out of 13 SFBT techniques measured by the Fidelity Instrument were implemented in 17 (85%) or more sessions. Three techniques were not consistently implemented by the social workers: "asking the client what he/she expected from the session," "eliciting clients to state needs related to the goals of the therapy," and "asking clients for feedback about the helpfulness of the session." Social workers assessed their performance with the same instrument and, in general, there was consistency between their responses and the analysis of the sessions.

Social workers, however, had the perception of having implemented more often the techniques that in the analysis of the sessions were identified as having been less frequently implemented. In addition, the sessions also involved problem-centered questions as clients presented their problems. When problem-talk appeared repeatedly in a session, the trainer supervised the subsequent sessions to coach social workers in moving from problem-talk towards solution-talk, which was a strategy to foster fidelity with the practitioners. Each social worker was supervised directly in at least three sessions, in which the trainer provided feedback before, during, and after the session. Sessions lasted between 30 and 60 minutes, and all sessions included a break.

The social worker:	Sessions *(n)*			Σ
	1 *(5)*	2 *(8)*	3 *(6)*	Total *f* *(%)*
Asked what the client wanted out of today's session.	3	3	3	9 *(45)*
Asked "what's better" in today's session.	5	8	7	20 *(100)*
The client's stated needs for today's session were related to overall goal(s) for therapy.	2	1	0	3 *(15)*
Summarized the client's comments during today's session.	4	7	6	17 *(85)*
Complimented the client's strengths/resources during today's session.	5	8	7	20 *(100)*
Asked exception/difference questions during today's session.	5	7	7	19 *(95)*
Asked amplifying questions during today's session.	5	8	7	20 *(100)*
Asked reinforcing questions (e.g., summarizing/ complimenting) of the client's reported change in today's session.	5	8	7	20 *(100)*
Was able to help the client behaviorally describe a next small step of progress.	5	7	6	18 *(90)*
Asked scaling questions during today's session.	5	8	7	20 *(100)*
Asked coping questions related to the client's abilities that emerged during today's session.	4	7	7	18 *(90)*
Asked questions to help the client think about how changes will affect the client's family and important others in their life.	4	7	7	18 *(90)*
Asked for feedback on the helpfulness of the session today from the client.	3	5	5	13 *(65)*

Table 6: Frequency Analysis of Interventions by Session

After finishing the program, each social worker was interviewed regarding their perceptions of the process. All four social workers stated that the concrete and easy-to-practice techniques was what they liked the most, where having the manual available was crucial. Two social workers highlighted the solutions- and resources-centered aspect as one of their favorite things of the approach. Regarding the difficult aspects, one social worker identified "staying silent," another one indicated, "keeping the structure of the session," and two others found it difficult to intervene with individuals who had some cognitive damage

or cultural deprivation because they needed to make an effort to reformulate some questions. In terms of changes to the program, three out of four social workers asserted that although the program is brief, three sessions may be too brief for some cases and that, in more complex cases, they would add more sessions and follow-ups. One social worker expressed that the fact that patients were compensated for participating in the study was confusing for her patients, and she suggested providing another type of compensation, or giving the compensation at the end of the program. Three social workers suggested adding more hours of training and supervision, including more instances of feedback from the trainer; and two social workers thought that this approach should be employed with other conditions that are treated in primary care settings.

Results of Pilot Implementation

As shown in Table 7, participants who completed the treatment were 14 years older, had lower educational attainment, reported lower "percent of days abstinent," higher "average of daily drinks," higher "alcohol use risk level," more severe "consequences of alcohol use," higher score in "depression index," and lower scores in "self-reported wellbeing" at the baseline than individuals who did not complete the treatment. Participants who did complete the treatment scored higher in the measure "Family Health" that focuses on family dynamics and family support and predicts family susceptibility to health issues (Püschel et al., 2012). When examining statistically significant differences between both individuals who completed treatment and individuals who dropped out, only "age" and "percent of days abstinent" were significant at 95%, whereas "educational attainment" and "alcohol use risk level" were significant at 90%.

A global visual analysis was conducted to examine trends of changes in outcome variables before and after the intervention. As such, the three outcome variables of alcohol use, "percent of days abstinent," "daily average of drinks," "and maximum amount of drinks in one day," changed in the expected trend—a decrease in alcohol use. Nevertheless, the magnitude of the changes had high variation across participants, which is observable in figures 1 to 4. The variables "alcohol use risk level" and "consequences of alcohol use," both measured only at the baseline and at one-month follow-up, showed the same tendency. In the former, the variability of scores increased in the follow-up, while in the latter, the variability of scores appeared to be more stable. Participants showed an increase in "self-reported wellbeing" and a decrease in "depression index." In addition, "family health" was the only outcome variable that did not change in the expected trend.

Further, we conducted PND analyses to quantify trends observed in visual analyses. As discussed previously, even when the observed trends in visual analyses moved in the expected direction, when observing the data per subject, differences emerged. Figure 2 shows PND analyses and visual representations for "percentage of days abstinent" during the last period per subject. The results across subjects are mixed. As shown in Figure 2, Subject 1 and Subject 4 reported 100% abstinence following the second observation, and this behavior was reported by them throughout all the subsequent observations. Thus, the PND analysis for these two cases is 0%. Although this analysis suggests that the program did not have any effect on the decision that these two individuals made to stop drinking, it may be possible that the program contributed to their decision. In parallel, PND analysis in Subject 3 and Subject 7 showed 33% because only in one observation of Phase B did both

cases report a "percentage of days abstinent" higher than the maximum point reported in Phase A.

	Complete Cases (N = 8)				Dropouts (N = 7)						
Background variables	Mean or %	SD	Min	Max	Mean or %	SD	Min	Max	*t* or X^2	df	*p*
Age	49.3	7.8	38	60	35	7.9	26	45	3.484	12.656	0.004
Income (x1000)	200	130.9	50	350	307.1	171.8	50	550	-1.343	11.173	0.205
Family size	3	2.7	1	8	2.9	1.8	1	6	0.123	12.208	0.903
Female	25				0				0.435	1	0.509
Relationship	50				71.4				0.100	1	0.751
Partner	37.5				48.9				1.376	1	1
Education									6.964	3	0.073
< Primary	12.5				14.3						
Primary	37.5				42.85						
< Secondary	50				0						
≥ Secondary	0				42.85						
Place A	50				29				0.100	1	0.751
Outcome Variables											
% Days Abstinent	32.9	31.5	0.0	91.8	72.8	23.9	23.7	96.7	-2.44	12.96	0.02
Average consumption	3.5	4.4	0.0	13.5	1.94	2.4	0.0	7.0	0.866	11.226	0.405
Maximum consumption	15.38	6.1	9.0	25.5	17.79	9.9	6.0	32.0	-0.577	9.704	0.589
ASSIST Index	29.12	5.4	21.0	39.0	21.0	10.4	8.0	36.0	1.863	8.802	0.096
SIP Index	51.5	13.3	27.0	73.0	44.86	17.9	22.0	70.0	0.804	10.989	0.438
Wellbeing Index	14.95	9.7	0.6	28.6	21.46	10.6	4.8	35.1	-1.234	12.35	0.240
PHQ Index	14.12	7.2	3.0	26.0	8.43	5.6	2.0	15.0	1.653	12.599	0.123
SALUFAM Index	3.43	1.4	0.1	4.4	2.96	1	1.7	4.5	0.761	12.535	0.461

Table 7: Descriptive Data of Demographics and Outcome Variables of Complete Cases and Dropouts Compared at Baseline

Although a visual trend indicates improvement during Phase B, the treatment did not have a significant PND effect for these two subjects. Subject 2 and Subject 7 showed 67% because, in two out of three observations of Phase B, they reported a "percentage of days abstinent" higher than the maximum point reported during Phase A. Although the visual trend suggests improvement in the last observation, PND shows no significant effect of treatment for these cases. Finally, Subject 5 and Subject 8 reported a PND = 100%

because all three observation points in Phase B were higher than the maximum point during Phase A. Only for these subjects does PND support that treatment had significant effects on "percentage of days abstinent."

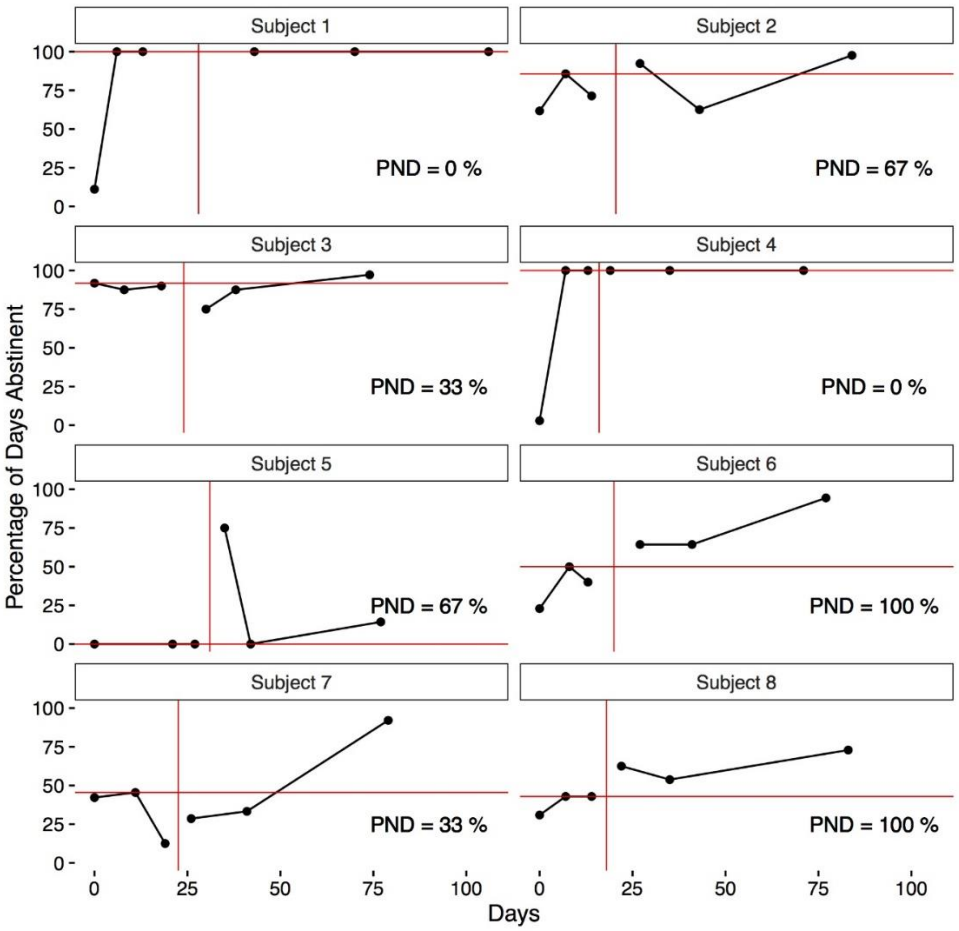


Figure 2: Visual and PND Analysis of Percentage of Days Abstinent per Subject

The PND analysis of "average of daily drinks" (Figure 3) and "maximum of drinks in one day" (Figure 4), showed no significant changes after the intervention, although in the global visual analysis, the trend showed a slight decrease, with seven out of eight individuals presenting a PND ≤ 33% in "average of daily drinks" and all the participants presenting a PND ≤ 33% in "maximum of drinks in one day." It is important to note that two of the subjects reported no drinks in two of the observations during Phase A, and thus

any of their observations during Phase B implied a change. In these two cases again, the intervention may have reinforced the maintenance of their decision. On the other hand, a PND analysis on "self-reported wellbeing" (Figure 5) obtained a Median = 67% though visual analysis shows the variability of these results across subjects. Nevertheless, seven out of eight subjects experienced higher levels of wellbeing in two or three observations during Phase B.

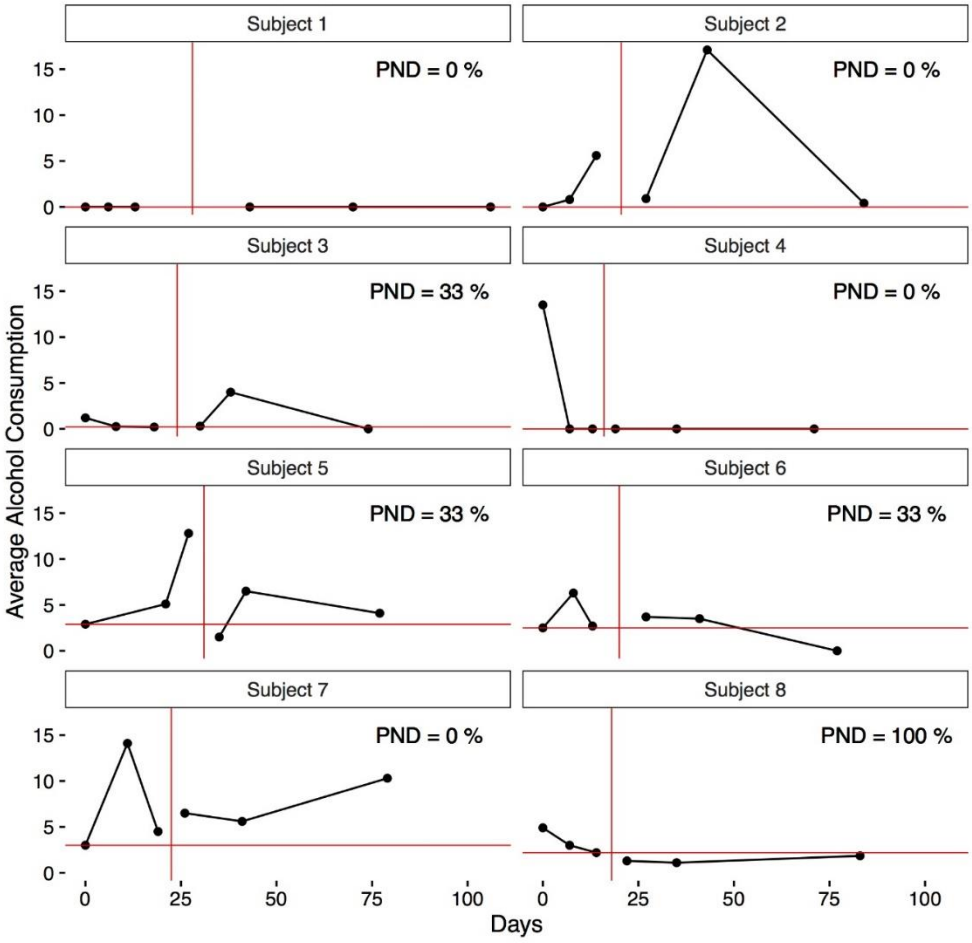


Figure 3: Visual and PND Analysis of Average of Daily Drinks per Subject

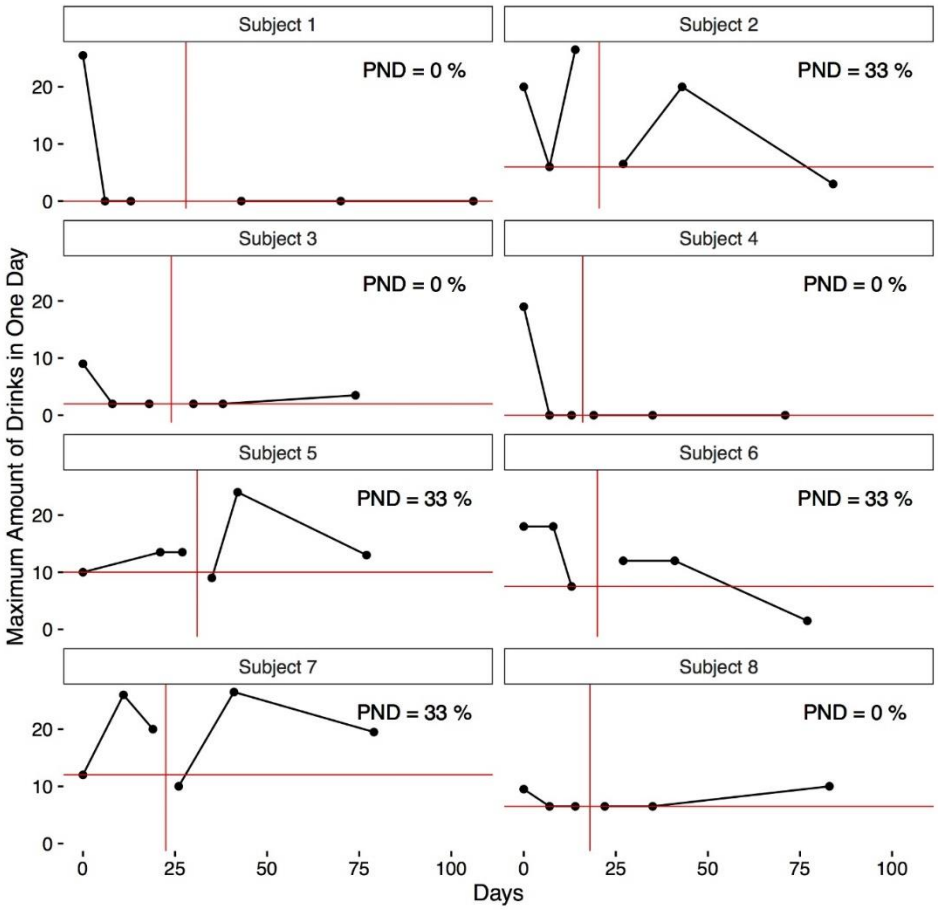


Figure 4: Visual and PND Analysis of Maximum Amount of Drinks in One Day per Subject.

Since variables of "alcohol use risk level," "consequences of alcohol use," and "family health" were measured at the baseline and at one-month follow-up, linear regression analyses were conducted (Table 8). Participants reported, on average, scores that were 8 points lower on "alcohol use risk level," $p = .056$, which although not significant, showed a positive trend that should be explored in future studies that include larger samples. Individuals who completed the treatment reported, on average, a significant drop of 28 points on "consequences of alcohol use," $p < 0.001$, suggesting that although alcohol use frequency did not decrease, participants may have found strategies to manage their

behavior and consequences of alcohol use after the treatment. Reports on “family health” did not show a significant change.

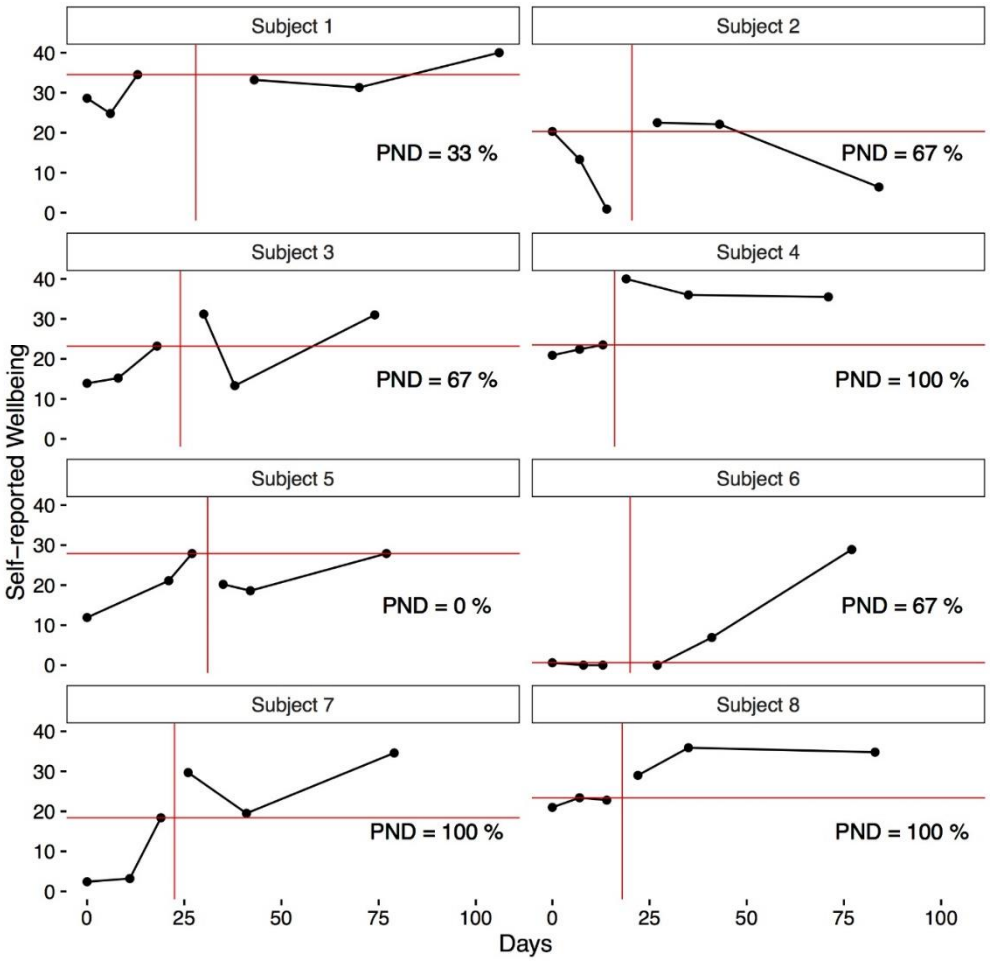


Figure 5: Visual and PND Analysis of Self-reported Wellbeing per Subject.

Finally, we conducted multilevel analyses on alcohol-related variables and on “depression index.” As stated in the section analysis plan, we considered two models: Model 1, examining the associations between Phase A and Phase B across subjects in the variables of interest; and Model 2, analyzing the associations between Phase A and Phase B, considering time as a control variable. Results of Model 1 and Model 2 are presented on Tables 9 and 10, respectively.

Linear Regression Model		Parameter	Parameter estimate	Robust SE
Family Health Index	Baseline level	α	3.43*	0.52
	Treatment effectiveness	β_1	0.33	0.53
Consequences of Alcohol Use	Baseline level	α	51.50*	5.03
	Treatment effectiveness	β_1	-28.63*	6.05
Alcohol Use Risk-level	Baseline level	α	29.13*	2.05
	Treatment effectiveness	β_1	-8.88	4.26

Note. *p < .05

Table 8: Linear Regression Models of Treatment Predicting Family Health, Consequences of Alcohol Use, and Alcohol Use Risk-Level

Findings associated to "percent of days abstinent" showed a statistically significant increase of 22% of during Phase B when running Model 1; whereas when controlling for time, the variable maintained its positive trend (8%), although it was not statistically significant. Participants diminished their "average of daily drinks" by only 0.7 cups, which is not statistically significant, neither while running Model 1 nor Model 2.

Individuals also reduced their "maximum amount of drinks in one day" between 3.5 (Model 1) and 1.4 cups (Model 2), although these results were not statistically significant. Consistent with findings in the visual and PND analyses, "self-reported wellbeing" showed a statistically significant improvement by 10 points when running Model 1; however, when controlling for time, this positive trend decreased to 5.7 points, and the statistical significance disappeared. Finally, individuals who completed the treatment improved their "depression index" score by 5.3 points when running Model 1. Similar to the other measures, when adding the variable of time, the magnitude of the improvement diminished, and the significance disappeared.

Multilevel Model	Parameter	Parameter estimate	SE
% Days Abstinent	Fixed coefficient		
Baseline level	θ_{00}	51.33*	10.52
Treatment effectiveness	θ_{10}	22.32*	7.04
	(Co)variance component		
Baseline level	σ^2_{u0}	26.39	
Treatment effectiveness	σ^2_{u1}	4.51	
Covariance baseline and treatment	σ_{u0u1}	-1.0	
Residual variance	σ^2_e	23.75	
Average Alcohol Consumption			
Baseline level	θ_{00}	3.56*	0.99
Treatment effectiveness	θ_{10}	-0.70	1.11
	(Co)variance component		
Baseline level	σ^2_{u0}	1.72	
Treatment effectiveness	σ^2_{u1}	0.15	
Covariance baseline and treatment	σ_{u0u1}	1.0	
Residual variance	σ^2_e	14.75	
Maximum Alcohol Consumption			
Baseline level	θ_{00}	11.29*	2.08
Treatment effectiveness	θ_{10}	-3.48	2.01
	(Co)variance component		
Baseline level	σ^2_{u0}	4.43	
Treatment effectiveness	σ^2_{u1}	1.45	
Covariance baseline and treatment	σ_{u0u1}	1.0	
Residual variance	σ^2_e	6.75	
Wellbeing Index			
Baseline level	θ_{00}	16.43*	3.31
Treatment effectiveness	θ_{10}	9.76*	2.09
	(Co)variance component		
Baseline level	σ^2_{u0}	8.37	
Treatment effectiveness	σ^2_{u1}	0.51	
Covariance baseline and treatment	σ_{u0u1}	-1.0	
Residual variance	σ^2_e	7.21	
Depression Symptoms (PHQ)			
Baseline level	θ_{00}	14.06*	2.52
Treatment effectiveness	θ_{10}	-5.31*	1.79
	(Co)variance component		
Baseline level	σ^2_{u0}	6.17	
Treatment effectiveness	σ^2_{u1}	0.36	
Covariance baseline and treatment	σ_{u0u1}	1.0	
Residual variance	σ^2_e	5.06	

Note. *$p < .05$

Table 9: Model 1 of Multilevel Modeling of Treatment effects on Outcome Variables Examined per Individuals and Observations.

Multilevel Model 2	Parameter	Parameter estimate	SE	
% Days Abstinent	Fixed coefficient			
Baseline level	θ_{00}	48.50*	10.88	
Treatment effectiveness	θ_{10}	8.33	10.69	
Linear temporal trend	θ_{20}	0.33	0.19	
	(Co)variance component			
Baseline level	σ^2_{u0}	27.34		
Treatment effectiveness	σ^2_{u1}	5.75		
Covariance baseline and treatment	σ_{u0u1}	-1.0		
Residual variance	σ^2_e	23.14		
Average Alcohol Consumption	Fixed coefficient			
Baseline level	θ_{00}	3.56*	1.03	
Treatment effectiveness	θ_{10}	-0.72	1.76	
Linear temporal trend	θ_{20}	0.0	0.03	
	(Co)variance component			
Baseline level	σ^2_{u0}	1.71		
Treatment effectiveness	σ^2_{u1}	0.17		
Covariance baseline and treatment	σ_{u0u1}	1.0		
Residual variance	σ^2_e	3.89		
Maximum Alcohol Consumption	Fixed coefficient			
Baseline level	θ_{00}	11.71*	2.16	
Treatment effectiveness	θ_{10}	-1.43	3.12	
Linear temporal trend	θ_{20}	-0.05	0.06	
	(Co)variance component			
Baseline level	σ^2_{u0}	4.51*		
Treatment effectiveness	σ^2_{u1}	1.32		
Covariance baseline and treatment	σ_{u0u1}	1.0		
Residual variance	σ^2_e	6.77		
Wellbeing Index	Fixed coefficient			
Baseline level	θ_{00}	15.6*	3.34	
Treatment effectiveness	θ_{10}	5.67	3.30	90%
Linear temporal trend	θ_{20}	0.10	0.06	
	(Co)variance component			
Baseline level	σ^2_{u0}	8.43		
Treatment effectiveness	σ^2_{u1}	2.5		
Covariance baseline and treatment	σ_{u0u1}	-0.38		
Residual variance	σ^2_e	6.97		
Depression Symptoms (PHQ)	Fixed coefficient			
Baseline level	θ_{00}	14.84*	2.55	
Treatment effectiveness	θ_{10}	-0.18	3.39	
Linear temporal trend	θ_{20}	-0.10	0.05	
	(Co)variance component			
Baseline level	σ^2_{u0}	6.21		
Treatment effectiveness	σ^2_{u1}	0.16		
Covariance baseline and treatment	σ_{u0u1}	1.0		
Residual variance	σ^2_e	4.86		

Note. *p < .05

Table 10: Model 2 of Multilevel Modeling of Treatment effects on Outcome Variables Examined per Individuals and Observations.

Results of Supplementary Analyses

To complement the findings of participants who finished the three-session treatment, we conducted supplementary analyses of multilevel models including all 15 cases—complete and dropouts. These results were consistent with most of the prior findings. Results of patterns of alcohol use remained similar to prior analyses and continued to change in the expected direction. As such, "percent of days abstinent" showed a statistically significant increase of 14.7% of days without alcohol consumption among participants in Model 1, whereas controlling for time (Model 2) the significance disappeared, although the average still improved by 4%. In regards to "self-reported wellbeing," even though the outcome changed in the expected direction by increasing 4.7 points from Phase A to Phase B, it became statistically non-significant in Model 1 and Model 2 when dropouts were included. On the other hand the "depression index" remained statistically significant when including dropouts, and participants reported an increase of 4.5 points in their score during Phase B. Similar to other analyses, when controlling for time (Model 2), statistical significance disappeared.

DISCUSSION

This study explored the implementation and effectiveness of a SFBT intervention with patients referred for alcohol use using single case designs at two primary clinics in urban low-income neighborhoods in Santiago, Chile. Eight out of 15 participants in the study finished a three-session solution-focused brief intervention that was linguistically adapted for this population. Frequency analysis of the fidelity measure indicated that the social workers who delivered the SFBT intervention adhered to at least 10 out of 13 techniques identified in the fidelity instrument, and direct supervision was additionally helpful to reinforce individual social workers' fidelity to the model. These results resonate

with the positive reception that practitioners reported regarding the model. On the other hand, the items that social workers implemented the least—"asking the client what he/she expected from the session," "eliciting clients to state needs related to the goals of the therapy," and "asking clients for feedback about the helpfulness of the session," involve the clients' active participation that should be elicited by therapists during the intervention. Paradoxically, social workers perceived that they did implement these interventions more consistently than they actually did. Three possible explanations appear regarding these findings. First, since the protocol designed for the treatment focused more on specific techniques of SFBT and did not include these aspects textually, social workers may have not implemented actions that resulted in client's self-determined goals or closely following the clients' language or the co-construction process during sessions. All are essential elements necessary to carry out the SFBT change process (Franklin, Zhang, Froerer, & Johnson, 2016). Second, a confusion may have existed in terms of future oriented questions that ask for what the client wants in regards to how these questions relate to the goals of the session and the therapy. Third, social workers may have not grasped the importance of asking for feedback about each session as a way to assess themselves and empowering clients, which is consistent with social workers' perceptions regarding the need for more training and supervision. Future trainings with social workers and an improved version of the protocol will emphasize the inclusion of interventions that consider the client-centered and resource perspectives of SFBT, including the importance of co-construction and the building of client cooperation and competencies. Social workers provided feedback on the program and suggested increasing the number of sessions and follow-ups, expanding the

approach to other health issues in primary care, and giving other types of compensation to participants. All of these are challenges to explore in future empirical studies.

Overall, this study showed mixed but promising trends and outcomes that can be further explored in future studies. In addition, the results from this study complement other research findings found in studies on alcohol use, including intervention studies on SFBT. Participants who completed the SFBT intervention were older, had lower educational levels and demonstrated more severe outcomes on alcohol use at the baseline compared to participants who did not complete the intervention. These data resonate with other studies showing that higher age is positively associated with adherence to alcohol treatment programs (Garcia & Mendez, 2014; Oslin, Pettinati, & Volpichelli, 2002; Brorson, Ajo Arnevik, Rand-Hendriksen, & Duckert, 2013). These baseline data contrast with other findings in which higher severity on alcohol use consequences predicted lower adherence to alcohol treatment (Kiluk, Dreifuss, Weiss, Morgenstern, & Carroll, 2013). Results also complement the findings reported by Cordero and colleagues (2009) in which patients with higher severity of alcohol use disorders were more likely to report better results after three-session SFBT intervention. These two studies are not replications and are not completely comparable; the equivocal findings between them suggests that future studies on SFBT interventions may want to compare adherence to and effectiveness of treatment by severity of alcohol use disorders.

Among alcohol outcomes, the clearest trend among participants who completed the treatment was the decrease in "percentage of days abstinent" in 22% at the one-month follow-up. Although this percentage decreased to 14% when including dropouts in the analysis, it remained significant. These results are consistent with other studies on SFBT

with alcohol users (de Shazer & Isebaert, 2003; Hendrick, Isebaert, & Dolan, 2012). A possible explanation for this variation of results that should be explored in the future—between including only participants who completed the treatment and including dropouts—is a positive selection where individuals who did not benefit from the intervention may have dropped out whereas individuals who benefited completed the treatment.

The variability of alcohol use frequency and quantity across the eight participants and their progression throughout the six observations contributed to mixed results in other alcohol outcomes such as "average of daily drinks" and "maximum amount of drinks in one day" which changed in the expected direction, but not significantly, even when including dropouts. Studies with patients that present more similar profiles and/or bigger samples should explore how these outcomes change over time. In addition, future studies of SFBT with alcohol use should consider longer follow-up ranges. On the other hand, participants who completed the treatment showed a decrease on their "alcohol use risk-level" as measured by the ASSIST tool, which trended to be significant ($p = .056$). In terms of clinical impact, participants moved from high risk to moderate risk (Soto-Brandt et al., 2014). Nevertheless, changes across participants varied from an increase of 7 points to a decrease of 30 points where, again, differences in subjects' alcohol use patterns suggest that results must be interpreted with caution and future research including larger samples may help to explain how SFBT treatment has different effects depending on clients' characteristics.

Another important finding is that individuals who completed the treatment reported a statistically significant decrease in "consequences of alcohol use" and "depression index" as well as a significant increase in their "self-reported wellbeing," suggesting a possible

harm reduction in which SFBT helped individuals improve in areas unrelated to alcohol outcomes. These results may relate to the focus of SFBT on clients' developing their own solutions and goals, which often resulted in work on a client's own behavior, family relationships, and living conditions instead of a singular focus on abstinence or alcohol use decrease. The "depression index" as measured by the PHQ-9 at one-month follow-up, for example, decreased 5.3 points, on average, which is considered clinically significant (Löwe, Unützer, Callahan, Perkins, & Kroenke, 2004). Although this clinical significance decreased when including dropouts, this may be related to the fact that individuals who did not complete the treatment had, on average, better scores on the "depression index" at the baseline. Further explorations should be conducted on this issue to examine how client characteristics and level of symptoms may impact the effectiveness of the SFBT intervention. The improvements found in this study on the "depression index" and "self-reported wellbeing" outcomes for alcohol users who finished the treatment specifically build on the study by Smock and colleagues (2008), where individuals participating in an SFBT intervention experienced a significant diminishment of their depressive symptoms and a significant increase in their psychosocial wellbeing. These findings further support previous research that has repeatedly shown that SFBT is an effective intervention for internalizing disorders, demonstrating decreases in depression and anxiety symptoms (Gingerich & Peterson, 2013; Kim, et. al., 2016; Schmit et al., 2016). More exploration is needed to understand the findings of "self-reported wellbeing" when including dropouts, in which case the results became non-significant and fell from 10 points of improvement to a score of 4.7. Possible explanations may relate to difficulties experienced by social workers while implementing the approach, specifically as it relates to employing specific techniques

for developing collaborative solutions with the client. Other areas to consider are the motivation of the client, their commitment to their goal, and the dosage or exposure that is needed for change to occur. Further process analysis of therapy interviews could help to understand the client characteristics and role of the social worker in contributing to the different outcomes between those that completed the intervention and those that dropped out. In addition, other instruments measuring treatment alliance may also help to understand why individuals dropped out of the program and felt less of an improvement in their wellbeing.

Finally, although the results were not significant, the fact that participants who completed the treatment had better scores than dropouts in the "Family Health" instrument may imply that individuals whose families had higher levels of support and agreement (Püschel et al., 2012) are more likely to adhere to a three-session program, which has been observed in past literature (Moos, Bromet, Tsu, & Moos, 1979). As a complement, when a significant other participates with treatment strategies to support patients, they are more likely to engage in treatment for alcohol use, and in some studies, family therapies have been found to be more effective than individual and group therapy (Miller, Meyers, & Tonigan, 1999, O'Farrel & Clements, 2012, Stanton & Shadish, 1997). These facts are consistent with a prior study in which drinkers stated that inviting significant others to treatment was important (Gonzalez et al., 2016). Therefore, future research on SFBT should examine how family characteristics predict adherence and how including the participation of significant others may improve adherence and outcomes of the SFBT intervention.

LIMITATIONS OF THE STUDY

The results of this study must be interpreted with caution. Even when some results showed statistical significance, the small sample and limited number of measures only allow for identifying trends regarding expected outcomes. These issues may imply a biased estimation of the random components of the model, and thus we need to prioritize for fixed effects in the interpretation. Second, due to the reduced degrees of freedom that the small amount of observations and cases allow, we could not include other control variables. Future research should include larger samples, more observations, and/or longer follow-ups to increase internal validity. Another limitation is the high number of dropouts from the study, since seven out of fifteen cases did not complete the six observations. Individuals who completed the treatment were statistically significantly older, presented lower "percent of days abstinent," reported lower "educational attainment," and higher "alcohol use risk level". In addition, when including dropouts in the analysis, the magnitude of the effect decreased; thus, the results also should be interpreted considering that individuals who finished the treatment obtained better results than those who dropped out and that these two groups were different, as mentioned above. Future studies may include follow-ups for people who did not finish treatment, explore these and other distinctive characteristics between individuals who finish and who drop out, as well as strategies for avoiding attrition. In terms of the training and preparation of practitioners, the fact that therapists needed more coaching to implement skills associated with the active participation of the clients indicates that future studies should examine whether adherence improves with better training on the change process of SFBT and whether social workers employed other specific strategies that are beyond what the fidelity measure assessed.

CONCLUSION

This is the first study to examine the effectiveness of a linguistically adapted version of SFBT on alcohol use in primary care within Latin America. Results are promising, although the study design suggests that findings must be interpreted with appropriate caution. SFBT showed reductions in alcohol risk and patterns of usage among participants. Improvements in alcohol consequences, depression and wellbeing were also found and were clinically significant. Interestingly, even in cases where alcohol use did not decrease, other mental health and wellbeing measures, including alcohol consequences, still improved, suggesting a possible harm reduction from the use of SFBT. These results complement other research studies on SFBT that have shown similar findings. Future research needs to focus on larger studies with randomized controlled designs and longer follow-up periods to substantiate these findings.

Chapter 5: Conclusions

The three prior chapters are a contribution to the incipient literature on brief interventions with Latinos and Latin Americans and, in particular, to Solution-Focused Brief Therapy (SFBT) for alcohol use disorders (AUDs). AUDs were selected because they have become one of the main causes of diseases and deaths in the world during recent years (World Health Organization, 2014), with Latin America being a critical region, especially Chile. This country has the highest average of alcohol consumption per capita among Latin American countries (World Health Organization, 2014). In addition, the last Chilean National Survey of Health (Encuesta Nacional de Salud 2009-2010) reported that 57% of the population, ages 15 years and older, consumed alcohol during the past month; and 36% consumed alcohol during the past week; moreover, the average alcohol consumption in this last group was, on average, more than 7 cups (Ministerio de Salud, 2011). Besides the efforts that Chilean Ministry of Health has made through national plans to provide brief interventions in primary care settings, no research on implementations had been reported. Given the magnitude and consequences of AUDs as a public health problem and the emerging health policies in Chile, research on brief interventions for alcohol use became an urgent need. A brief intervention approach to explore in this context was Solution-Focused Brief Therapy (SFBT), which is a culturally respectful approach that considers individuals' interpersonal context and relies on cooperation (Corcoran, 2000; Oliver & McNichols, 2011), which is naturally adaptable for Latino cultures.

Chapter 2, "Solution-Focused Brief Therapy with Latinos: A Systematic Review" is a starting point for examining the available research on SFBT with Latinos. This chapter presented an exhaustive search of the literature of empirical studies, accounting for the application of this approach with Latinos in the US and Latin America. Despite the small number of quality empirical studies, the trend among these studies suggested that SFBT is a promising model to implement with individuals in several settings such as mental health and schools, including older adults, adults, adolescents and children. It is notable that the study implemented in Chile by Schade and colleagues (2011) showed that the implementation of SFBT, combined with strategic therapy, had a significant effect on the cost-efficiency of medical costs at the primary care level, when treating individuals with somatoform disorders. In this regard, SFBT could be a suitable approach for primary care due to its brief format and flexibility, and future empirical studies on SFBT compared to other approaches in primary care should continue to explore its effectiveness in Latin American primary care settings.

The two following chapters built on the findings of the first chapter's systematic review, especially regarding the interventions developed for mental health in primary care settings, in at least three ways. First, Latin American studies showed that SFBT has been efficacious with mental health conditions such as depression, anxiety, and alcohol use; and it is known that alcohol use disorders are highly associated with depression and anxiety. Thus, examining the applicability of SFBT with individuals with alcohol use disorders represents a continuity on the development of research on SFBT in mental health with Latin American populations, and it also builds on the studies that have

examined its effectiveness with substance use (e.g.: Kim et al, 2016; Smock et al., 2008) . Second, no records of linguistic or other cultural adaptations on SFBT and on any brief intervention with alcohol use disorders have been found in the extant literature in Latin American countries. Therefore, it was relevant to explore a linguistic adaptation of SFBT to the Chilean population and to examine its applicability with individuals with AUDs. Third, a high proportion of alcohol use disorders and depression are treated at the primary care level in the Chilean health system; thus, a linguistically adapted and manualized treatment that is brief and may be cost efficient for these mental health conditions is an important contribution to practitioners, implementers, and Chilean policy makers. It may also be extendable to other Latin American countries.

In this vein, Chapter 3 reported on a study regarding the explorative linguistic adaptation of SFBT to a Chilean clinical population that uses alcohol. The purpose of this study was to examine participants' comprehension of specific SFBT techniques and to make sure the language was appropriate for use in a clinical setting. The results suggested that SFBT's main techniques were understood by most of participants after changing some words that helped to clarify the techniques. In addition, since in Chilean culture alcohol use by women has an extremely negative connotation, practitioners should consider techniques oriented to destigmatize women who are users of alcohol through externalization of the problem, such as "What happens when alcohol is not in your life?" instead of "What happened when you were not an alcoholic?" Moreover, participants made the suggestion that future studies might consider inviting significant others such as family members, friends or neighbors that individuals in treatment identify as supporters.

The findings of Chapter 3 contributed to the formulation of a three-session manualized intervention that was piloted in two primary clinics in Santiago, Chile. This pilot implementation is reported in the fourth chapter. The goals of the study presented in Chapter 4 were to explore the feasibility of implementing SFBT by social workers in primary care clinics and to observe trends in the outcome variables after this brief intervention. The study was a single case design with eight replications where participants were measured on six occasions: three prior to the intervention, two during the intervention, and a one-month follow-up observation. As such, eight participants completed the three-session program implemented by four social workers, who were previously trained in the SFBT approach. Social workers were able to implement most of techniques measured by the SFBT Fidelity Instrument. Techniques such as "asking what is better," "compliment strengths and resources," "amplifying and reinforcing questions," and "scaling questions" were practiced by all social workers in all assessed sessions, whereas techniques such as "asking clients what they want of each session," "encouraging clients to state their needs related to the goals of the therapy," and "asking for feedback on the helpfulness of the session" were the least implemented. This assessment uncovers the need for some improvements of the developed training and manual in order to strengthen the fidelity of the implementation. As for the effects of the treatment, the main results suggested positive trends in increasing the number of days abstinent and self-reported wellbeing and decreasing depression index scores and consequences of alcohol use scores. It is necessary to recognize that the small sample size

makes it impossible to generalize and obtain strong conclusions regarding the application of SFBT with alcohol users in Chilean primary care.

Implications for Social Work Practice

This dissertation represents a contribution to the development of evidence-based practice research on social work clinical interventions in Latin America. Historically, social workers in Latin America have focused on studies regarding social phenomena and theories about those phenomena, becoming a social science with a vast expertise on social issues and macro social policy. However, in field practice, social work is much more varied. Many social workers are implementers of social policies and programs in clinical settings, such as child welfare agencies, mental health, and primary care. Therefore, they need to be trained in and informed regarding evidence-based practices that guarantee the success of their interventions. This dissertation is a complete work that synthetizes evidence, linguistic adaptation, manual, guide, and pilot results of SFBT for Latin American social workers in primary care that are searching for a brief intervention to implement their field.

In terms of practical issues, social workers participating in this study considered that SFBT was a concrete, applicable, and useful approach to be implemented in primary care with alcohol-related issues as well as other health conditions. However, more training is needed to ensure the fidelity of the intervention when it comes to the process of collaboration. Nevertheless, this is a great opportunity for social workers to position their practice in primary care as a specialized discipline in psychosocial brief

interventions that could be cost-effective and could also contribute to enriching the skills that until now social workers have displayed.

There are three challenges to developing brief interventions in Latin American social work. A first challenge is continue to developing Latin American research on the applicability of linguistically adapted evidence-based practices while keeping the fidelity of the programs. A second challenge is to develop randomized controlled trials in these countries in order to provide social workers with evidence-based practice to inform their interventions. A third challenge refers to the dissemination of results for social workers in approachable ways that include Spanish-written manuals and handbooks compiling evidence-based practice in social work interventions and fields.

IMPLICATIONS FOR SOCIAL WORK EDUCATION

Similar to the development of research, in Latin America, social work education has focused more on macro practices rather than on clinical practice. In this regard, social work programs are not responding to practical and field needs, and therefore the need for curricula and programs of study is tremendous. This dissertation is groundbreaking in the field of social work in Chile since it serves to create awareness regarding the need to produce research that responds to practical needs of social workers. As such, it challenges social work schools in several ways. Undergraduate students should be familiar with evidence-based practices. Graduate students should receive training in brief intervention approaches that provide them with specialization in certain fields. However, until now, social work professors have to make concerted efforts to educate themselves and establish inter-professional and, if needed, international collaborations in order to acquire

the skills needed to teach and train future social workers in brief interventions that respond to practical needs. Social work schools need to be able to adjust their curricula and respond to real needs of social service agencies. In this sense, known skills such as phenomena diagnoses and macro assessments will be useful to uncover practice needs, but then, we will need to take charge on how to respond to them. Incorporating practical training in Latin American social work programs offers a tremendous opportunity to bolster the future of social work as a professional career and represents a contribution that can improve clients' lives.

FUTURE DIRECTION IN RESEARCH ON SFBT

Next steps for research on SFBT with Latin Americans include continuing to develop studies on linguistic adaptations to SFBT to ensure surface validity of the intervention across Latin American countries. After that, more research in different fields of social work intervention should be developed. In primary care, for example, a next step would be randomized controlled studies on SFBT with alcohol use. These studies should also include individuals from different age groups, so that it is possible to observe effects of the treatment across ages. In terms of alcohol use research, studies should be able to determine effects for individuals of different levels of AUDs (mild, moderate, and severe), as well as examine other demographic variables. Then, experimental studies including different types of interventions would provide more complete information regarding the effects that different approaches may have on outcome variables. Since results of these studies have shown that considering family in the interventions does matter for Latin American individuals, future research should compare the effects of

family participation in interventions. Other mental health conditions such as depression and anxiety should be included in future studies, also exploring family characteristics and family participation as important variables. Other fields of social work interventions may include child welfare agencies such as residential homes, preventive programs, and family interventions for cases of child abuse. Moreover, since research on SFBT with children and adolescents at schools has been already carried out with Latinos in the United States, and there are several reviews suggesting positive results from these interventions, future research should explore SFBT interventions in Latin American schools.

CONCLUSION

This dissertation has set the basis for recognizing the contribution that social work makes in primary care and other fields of clinical practice and for including clinical evidence-based practice in social work programs in Chile and the rest of Latin America. Next steps comprise further examination of culturally adapted brief interventions for alcohol use disorders and for other mental health conditions in Chile and other Latin American countries. Future challenges include: conducting randomized controlled trials of adapted SFBT and comparing it to other approaches; dissemination of results that allows Latin American practitioners to implement this approach; and presentation of the results to policy and decision makers in order to influence in the design of health policy as well as training of health providers.

Appendices

Appendix A: IRB Protocol for Linguistic Adaptation Study Reported in Chapter 3.

Title

Cultural Adaptation of Solution Focused Brief Intervention for Individuals with Alcohol Use Disorders in Chile.

1. Principal Investigator

Karla Gonzalez, PhD © uteid: kg23857, Department: School of Social Work
Cynthia Franklin, PhD (Chair)

2. Purpose

The purpose of this study is to conduct a cultural adaptation of the Solution-focused Brief Therapy (SFBT) approach to be culturally sensitive to Chilean, low income population living in Santiago, Chile, specifically for those who have alcohol use disorders. SFBT is a strengths-based, client-centered approach that evolved from the systemic approach, brief therapy, and family therapy. As such, it considers not only individuals aspects, such as behavior or intrinsic motivations, but also their contexts and their interactions with significant others. In this sense, SFBT is potentially sensitive to different cultures, such as the Latin American culture to which Chile belongs.

Prior research showed that culturally adapted brief interventions have more acceptance among recipients (Resnicow et al., 2000) and has been more effective than other culturally adapted brief interventions (Lee et al., 2013). Whereas no research has reported a cultural adaptation of SFBT for individuals with alcohol use, one study developed in Mexico informed positive outcomes in individuals with alcohol use disorders who received SFBT (reduced alcohol use patterns and problems associated with alcohol use; Cordero et al., 2009). SFBT may be a potential approach to apply among Chilean population, and since it has not been culturally adapted, its core techniques and interventions should be examined for cultural sensitivity. Additionally, specific aspects related to alcohol use, such as domestic violence, depression and anxiety, and other life dimensions affected by this behavior should be examined as part of a cultural adaptation.

This study hypothesizes that:

1. SFBT techniques and interventions will be accepted among Chilean population, however, potential clients will make observations to the use of specific language and the formulation of certain questions that the approach includes.
2. The incorporation of these observations will make the approach a stronger tool for intervening with individuals with alcohol use disorders.
3. Alcohol use will be described as an issue that negatively affects family relationships, mental health conditions, and other life dimensions.
4. Alcohol use is a substance that individuals use for entertainment and social life but that men and women, youth and older individuals, use differently.

3. Procedures

To develop the cultural adaptation of SFBT to Chilean culture, we will conduct a qualitative design where the data collection method will be two focus groups with individuals who live closer to the clinic where the adapted intervention intends to be implemented and 8 individual interviews. Each focus group will be audio-recorded on a digital recorder and then, they will be transcribed. Since interviews will be conducted in Spanish, they will be transcribed and analyzed in Spanish. Audio files will be downloaded and stored on a password protected hard drive for 90 days, after which they will be deleted. Transcriptions will be kept in the same hard drive. The transcriptions of the focus groups will be uploaded into NVIVO or other qualitative data software. Data will be analyzed by the PI, using a Content Analysis approach. The focus groups will include questions related to the specific techniques of SFBT and to the factors that are associated with problematic alcohol use.

a. Location

The study will be undertaken at The University of Texas at Austin School of Social work. Participants will be recruited from the communities located in La Pintana county. The PI has a longtime relationship with the communities located in this area due to her job in community development and health promotion between the years 2006 and 2012. In addition, she has contacts with community leaders who will serve as key informants and recruiters of potential participants of the study (See letter of Support in Appendix 1).

b. Resources

To support this research, personal resources such as personal transportation, cellphone, personal laptop, and personal audio-tape digital recorder will be employed. Meetings will be conducted in the community headquarter of the

Poblacion Jose Pedro Alessandri, located in Avenida El Ombu # 1901, La Pintana, Santiago-Chile.

c. Study Timeline
Data collection will be conducted in October and November 2015. The qualitative data analysis will occur during November and December 2015. Because this study will inform a following pilot study, the dissemination of the findings will take place in August 2016, together with the other study

4. Measures

The focus group guide and the interview guide were designed specifically for this project. The focus group contains open questions oriented to examine the main cultural aspects related to alcohol use disorders in Chile, such as typical places in which alcohol is used, typical drinks that are used, typical amount of alcohol consumption, and acceptability of alcohol use across genders, age groups, and contexts. The individual interviews will include a section to get information to adapt the core interventions of Solution-focused brief therapy approach to the culture of individuals who drink alcohol in Santiago, Chile. For example, it will include the exposition of generic questions employed in the approach and ask the participants for feedback regarding the wording, clarity, and other aspects that participants may observe in order to make these questions understandable in the context they will be employed. The methodology that will be employed in the interviews is Cognitive Interviewing (Beatty & Willis, 2007), which will allow us to understand the best ways to develop the cultural adaptation of the SFBT approach.

5. Participants

a. Target population
Target population are men and women 18 years old and older who live in La Pintana, Santiago. It is expected to have 6 to 8 participants per focus group, which in sum will be 18 to 24 participants.

b. Inclusion/Exclusion
<u>Inclusion criteria:</u>

- 18 to 65 years old
- Live in La Pintana
- Have had at least one heavy alcohol use episode in the past year

- Agree to participate voluntarily in the focus group

Exclusion criteria:

- Present any impediment to verbally communicate with others
- Does not meet all inclusion criteria

c. Benefits

Participants will receive no direct benefits from participating in this study. However, as they are contributing to the development of an intervention that could be useful for people like them, they could receive social benefit. In addition, the participants of this study may receive benefits from having the opportunity to express their opinion regarding an issue of their concern. The societal benefits will be to have a rigorous observation of the relevant information needed to culturally adapt this approach in Chilean, underserved population. This will be the first cultural adaptation of any intervention approach for alcohol use disorders in Latin America. Thus, it is an important contribution to the field of primary care and the quality of the services for individuals with alcohol use disorders, particularly in Chile.

d. Risks

The risks involved in participating in this study are not greater than those participants would experience in their everyday lives. We will collect participants' phone number and name/nick name only for the purpose of setting their participation in the focus group. This information will be deleted once the individual has participated in the focus group. The audio-taped focus groups will be deleted after 90 days of being conducted and no name or identifiable information will be kept in the transcriptions.

By participating in the focus groups, individuals are exposed to the risk of losing their privacy when disclosing personal situations related to alcohol use and its consequences. Interviewers will be prepared with information of agencies that can assist individuals who feel distressed and need additional support after the focus group. The PI will be available to talk to participants if some of them have a negative reaction during the interview. If a participant needs additional support due to continued emotional distress, transportation to a local mental health facility will be provided and the PI will accompany the participant.

All data will be kept strictly confidential. Any research assistant who have access to data will be trained about confidentiality. The minimal potential risks that

individuals may be exposed by participating in the focus groups are reasonable since the information that will be obtained through this research will be useful to develop culturally sensitive and evidence-based brief interventions for individuals who use alcohol, which are virtually non-existent for Chilean population. Thus, the information that emerges from this study will be a valuable contribution to clinical social work practice in Chile and Latin America.

e. Recruitment

The potential participants of this study will be recruited through two strategies:

- Community leaders: Community leaders will help to locate volunteers to participate in focus groups and will provide them with PI phone number or will share individuals' phone numbers and name or nick name with the PI. The community leader will only share community members' information if they consent, by signing a "consent to share my information" (See appendix 7) in which potential participants authorize the community leader to share their name and phone with the PI. This document will contain the name (or nickname) and the phone number of the potential participant. The community leader will be instructed to give all the signed "consents to be called" to the PI.
- Snowball. If a potential participant knows somebody who may want to participate the PI will share her professional cards with her phone number to invite him/her to participate.

Since the inclusion criteria includes having a heavy drink episode during the past year, the PI will personally and in private ask the potential participant about this criteria. The question will be: Have you had a time when you drunk four or more cups of alcohol on one occasion during the past year? If the answer is yes, then the individual will be invited to the study. See Script versions in Appendix 1 and 2.

All the information of potential participants and individuals invited to participate in the study, will be kept in a locked shelf in her office, located in the School of Social Work of The Catholic University of Chile (Av. Vicuna Mackenna 4860, Macul, Santiago, Chile).

f. Obtaining Informed Consent

The potential participant will be informed of his/her rights and aspects of the project at the moment of the invitation in the phone call or in person interview. Additionally, a written Informed Consent will be provided and read at the beginning of the focus group meeting. The informed consent includes an overview of the study, an explanation of voluntary participation, potential risks and benefits, and confidentiality. The informed consent will contain also contact

information of the Principal Investigator. The informed consent will be read at the beginning of each focus group.

Since the participants' language is Spanish, the Informed Consent will be in Spanish. The PI is Chilean and her native language is Spanish, thus she has made sure the language employed in the IC is accurate and understandable.

6. Privacy and Confidentiality

Privacy: At the beginning of the focus group or interview the researcher will ask the participants to state their first name OR the name that they want to use for the meeting. No information about participants will be shared between participants. The focus group guide will not include questions regarding personal experiences but general thoughts and beliefs.

Confidentiality: Since the focus groups or the interviews will be audio taped for later translation, these names will be modified in the transcription and the tape records will be destroyed once the transcription is complete. In addition, an agreement of confidentiality and respect for each other will be signed together with the informed consent, which will be stated before starting the focus group. See appendix 8.

7. Compensation

No economical compensation will be provided for participating in the focus groups. However, a sandwich and non-alcoholic beverages will be provided at the meeting.

8. International Research

This study will be conducted in Chile. The researcher is a Chilean social worker and she is interested in developing culturally sensitive, evidence-based brief interventions in health settings that serve vulnerable populations. The researcher worked for 9 years as a social worker in her country. She spent the last six years working in La Pintana at a primary health clinic called Juan Pablo II. At this clinic she developed several functions such as clinical work with individuals and families, and community work such as health promotion, community development, and needs assessments. In addition, her comprehensive examination during her doctoral studies was on brief interventions for alcohol use in Latin America, where her main focus was the policy, programs and practice around this topic in Chile. This research will be an initial contribution for clinical practice of social workers in health settings.

Individual Interview Guide

English Version

Solution-focused brief therapy technics.

Good morning (afternoon, evening). My name is _____and today I am in charge of conducting this interview. Thank you so much for giving me the opportunity to interview you. This interview is to gather your thoughts about the contents of a specific type of brief therapy to help people to feel better with their lives.

To this end, I would like you to listen very carefully the questions I am going to state and you tell me what you believe or what you understand from what I say. This is very important for this research because these questions were formulated in another language so by translating them, it may be difficult to understand their sense. To that end, we need your opinion so that they are understandable for our Chilean folks.

This interview will be audio-taped, which will allow us to analyze the contents anonymously. Your name will be modified, and once transcribed, the recordings will be destroyed.

(Questions for the beginning of the session):

What things have been better in your life since you get the appointment to come to see me?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

How would you like things to be in your life when the problem that brought you here does not exist?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

(Preguntas de escala)

These questions are initially with numbers, and I want you to tell me how you can understand them better.

On a scale from 1 to 10 in which 10 is where you want to be, your goal, and 1 is the worst that you can imagine you can be, at what level are you now?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

How do you know / note that you are at this level and not lower?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

How did you do it to be all the way up to this level and not lower?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

(Asking for exceptions through scaling questions)

Are there times in which you felt you were at least a little bit better (or much better, or wost: ask the three versions) If so, how did you do it (how did you managed to not being worst?)

Please, tell me what do you believe (or what do you understand) from what I am asking you.

Who may notice that things are better?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

At what level of the scale would they say that you are today?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

Why do you believe that they would say you are at that level?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

What is it that this person sees in you that he/she puts you in this level and not lower?

(Preguntas enfocadas en el futuro cercano)

Imagine that we travel into the future, one week later, this is seven days from today, and things are better, at what number on the scale we have been talking about will you be?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

Imagine that is the end of this sesión and you go home with the sensation that this conversatin that we had today was useful, how do you know or in what do you notice that the sesión was useful?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

What would be one thing you could do in the next 24 hours that would improve the chances that you achieve a better number (or in a better situation) on the scale we have been talking about?

Please, tell me what do you believe (or what do you understand) from what I am asking you.

(Experiment)

I want to ask you that from now to the next session you pay attention to the little things that would help you to progress towards this future place you want to be when the problem does not exist.

Please, tell me what do you believe (or what do you understand) from what I am asking you.

Is there anything else do you think I should ask?

Do you have some questions for me?

Thank you very much for participating in this study. I am sure your contributions will be very useful for people who receives the culturally adapted therapy.

Spanish Version

Técnicas de la terapia breve centrada en soluciones.

Buenos días (tardes, noches). Mi nombre es _____ y hoy estaré a cargo de conducir esta entrevista. Muchas gracias dejarme entrevistarle. Esta entrevista es para a recoger su opinión sobre los contenidos de un tipo de terapia breve para apoyar a las personas a sentirse mejor con sus vidas. Para ello quisiera que a continuación ustedes escuchen con mucha atención las preguntas que voy a decir y me diga qué cree o qué entendió usted que yo les estoy preguntando. Esto es muy importante para esta investigación porque estas preguntas fueron planteadas primero en otro idioma, por lo que al traducirlas puede ser difícil entenderlas. Por ello, necesitamos de su opinión para hacerlas entendibles para nuestra población chilena.

Esta entrevista será grabada en audio para luego analizar los contenidos anónimamente. Su nombre será modificado y una vez transcrita, la grabación de audio será destruida.

(Preguntas de inicio de la sesión):

¿Qué cosas han estado mejor en su vida desde que te dieron la hora para venir a verme?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

¿Cómo te gustaría que fueran las cosas en su vida cuando el problema que le trajo aquí ya no exista?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

(Preguntas de escala)

Estas preguntas son inicialmente con números, y quiero que ustedes me digan de qué manera se entienden mejor.

En una escala de 1 a 10 donde 10 es donde tú quieres llegar, tu meta, y 1 es lo peor que imaginas que puedas estar, ¿en qué nivel te encuentras hoy?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

¿Cómo sabes/ en que notas/ como te das cuenta/ que estás en ese número y no más bajo/peor?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

¿Cómo lo has hecho para lograr estar a este nivel y no estar peor?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

(Preguntar por excepciones y coping a través de las escalas)

¿Ha habido veces en que sientes que estuviste al menos un poquito mejor (o mucho mejor, o peor)? Si es así, ¿cómo lo hiciste (para o estar aún peor)?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

¿Quién podría notar (quien se daría cuenta) que las cosas están mejor?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

¿En qué número/nivel de la escala dirían ellos que tú estás hoy?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

¿Por qué crees tú que ellos dirían que estas en ese nivel?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

¿Qué es lo que esta persona ve en ti que te ubica en este nivel y no en un nivel más bajo o peor?

(Preguntas enfocadas en el futuro cercano)

Imagine que viajamos al futuro, a una semana después, es decir, viajamos siete días desde hoy (decir el día) y las cosas están mejor, ¿en qué número de esa escala que hemos estado hablando se encontrarás?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

Imagine que es el final de esta sesión y usted se va a su casa con la sensación de que la conversación que tuvimos hoy le sirvió ¿Cómo sabe usted/cómo se da cuenta/en qué nota que la sesión fue útil?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

¿Qué podría ser una cosa que usted pudiera hacer en las próximas 24 horas que mejorarían las posibilidades de que usted logre estar en un mejor número en la escala (o en una mejor situación) que hemos estado hablando?

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

(Experimentos y tareas para la casa)

Quiero que de aquí a la próxima sesión ponga atención en las pequeñas cosas que le ayudarán a avanzar hacia ese lugar o imagen que usted tiene de cuando el problema ya no esté.

Por favor dígame qué cree usted (o cómo entiende) que le estoy preguntando.

¿Hay algo más que ustedes crean que yo debiera preguntar?

¿Tienen alguna otra pregunta para mí?

Muchas gracias por participar en este estudio. Estoy segura que sus aportes serán útiles para personas que reciban la terapia una vez adaptada a nuestra cultura.

Focus Group Guide

English Version

Focus Group Interview Guide

Introduction:

Good morning (afternoon, evening) everyone. My name is _____and today I am in charge of conducting this meeting. Thank you so much for attending. We invited you to participate today because we are very interested in gathering your opinion regarding some issues that are related with lifestyles and how these have an impact on other aspects of people's lives such as relationships, job, or other areas.

To this end, I will be asking questions and I want you all participate one at a time and give us your most sincere opinion. All answers are good and useful for this study. Thus although there are differences, it is very important that all of you state your thoughts, being respectful with each other. Everyone will have his/her turn to talk and express themselves.
I would like to read some participation rules:

- Let´s talk one at a time. If you have something to contribute, please rise your hand and wait until I give you the time to speak.
- Let´s call each other by their names (written in the nametag).
- Let´s use a respectful and inside tone of voice so that each person in the room can listen each of your opinions (do not yield, do not whisper).
- Let´s turn off or set your cellphones in silence mode so that we keep the guiding thread of the conversation.
- Let´s respect others' privacy and confidentiality. All what is talked here will stay in this room. Therefore, so not commentary of the contents of this meeting with people who did not participate in this meeting.

This meeting will be audio-taped, which will allow us to analyze the contents anonymously. Your names will be modified, and once transcribed, the recordings will be destroyed.

<u>I would like to ask you about certain things related with alcohol use.</u>

1. What are the alcoholic beverages that you consume the most?

   -What are these preferences based on?
   -Are there differences between men and women? Which ones?
   -What are these differences based on?
   - Are there differences around people's age depending on the amount of alcohol they use? Which ones?
   -Are there differences between men and women in terms of the age and amount of alcohol that they use?
2. What are the most typical occasions in which you use alcohol (or some of the names that they use for alcohol)? Please, give some examples

   - (probe: Doing a party, inviting relatives, barbeque, etc.)
   - Besides consuming alcohol, what other things do you do in those occasions? (dancing, cooking, talking, laughing)
   -Who brings alcohol?
   -Who uses alcohol? (everyone, only adults, some of the attendants, the home owner, only men, etc)
   -Where do you commonly obtain alcohol? How easy is to get it?

-Why do you get it there and not in other places? What is different between this place and the others?

- Are there differences between the places or occasions in which is socially OK to consume alcohol for men and not for women or vice-versa?

3. How many drinks is the normal that you have when you drink?

- Number of drinks
- Types of beverages
- Is this different between men and women? Why?

4. What are the moments in which you do not use alcohol, in which according your customs is not OK to use alcohol?

-What do you do in those occasions? What is different to the occasions in which alcohol use s OK?

5. What would be important for you in a therapy for diminishing excessive alcohol use includes?

-Who should participate?
-What type of things should be talked?
I would like to talk about how people around you influence your lives.

6. Who are the most important persons in your lives? Probe: friends, family, wife, etc.)

-(if they mention the family, ask for what family members, if they do not mention family members, ask for the family: Y qué pasa con la familia?)

7. How do these people influence what you do or what you do not do?

- Some examples: probe we always talk about stuff, they help me to make decisions, they do not allow me to do certain stuff, etc.
- ¿What do these people say or do in regards to your alcohol use? Examples about what family says or do?

8. ¿What important areas of life are affected by excessive alcohol use?

-How?
-What are the most affected? Why? How?

9. Who around you (or what institutions, agencies, or other in the community) question or disagree with your excessive alcohol use? (probe: those who act as external control or regulators for alcohol behavior)

Spanish Version

Guía de Entrevista Grupo Focal

Introducción:

Buenos días (tardes, noches) a todos. Mi nombre es _____ y hoy estaré a cargo de conducir esta reunión. Muchas gracias por atender a esta reunión. Les

invitamos a participar hoy día porque estamos muy interesados en recoger su opinión respecto de algunas cosas que se relacionan con el estilo de vida y como éste repercute en otros aspectos de la vida tales como las relaciones con otros, el trabajo u otras áreas. Para ello yo les voy a ir haciendo preguntas y la idea es que todos participen de uno a la vez y den su más sincera opinión. Todas las respuestas son buenas y útiles para este estudio por lo que aunque existan diferencias, es importante que todos digan lo que piensan, manteniendo el respeto por el otro. Todos tendrán su turno para hablar y tiempo para expresarse.
Me gustaría leer algunas reglas de participación:

- Hablemos de uno a la vez. Si tengo algo que aportar a lo que alguien está diciendo, levanto mi mano y espero que me den la palabra.
- Llamemos a las otras personas por su nombre (escrito en la tarjeta que cada uno tiene).
- Usemos un tono de voz respetuoso y que cada persona que está en la sala pueda escuchar (no gritar, no susurrar).
- Apaguemos los celulares o usemos el modo en silencio para mantener el hilo conductor de la conversación.
- Respetemos la privacidad y confidencialidad de todos los presentes. Todo lo que se converse aquí se mantendrá en esta sala, por lo tanto, no comentaremos lo aquí tratado con personas que no participaron en la reunión.

Esta reunión será grabada para luego analizar los contenidos anónimamente. Sus nombres serán modificados y una vez transcrita, la grabación de audio será destruida.

Ahora quisiera preguntarle por ciertas cosas relacionadas con el uso de alcohol.

1. ¿Cuál o cuáles son las bebidas alcohólicas más comunes que ustedes consumen?

-¿Hay diferencias entre hombres y mujeres? ¿Cuales?
- ¿En que se basan estas preferencias?
- ¿Hay diferencias en la edad de las personas que toman según la cantidad de alcohol que toman?
- ¿Hay diferencias en la edad entre hombres y mujeres según a cantidad de alcohol que toman?

2. ¿Cuáles son las ocasiones más típicas en las cuales ustedes consumen alcohol (o alguno de los nombres que ellos mencionan en la pregunta anterior)? Díganme algunos ejemplos…

-(probe o ejemplos: Hacer una fiesta, invitar a los familiares, parrillada, etc.)
- ¿Además de consumir alcohol, que otras cosas ustedes hacen en esa ocasión? (bailar, cocinar, conversar, reírse)
-¿Quién o quienes proveen/traen/ alcohol?

-¿Quienes consumen alcohol? (solo los mayores, todos, algunos, el dueño de casa, solo los hombres… etc.)
-¿Dónde ustedes obtienen/compran comúnmente alcohol? ¿Qué tan fácil es obtenerlo?
-¿Por qué ustedes obtienen/compran allí y no en otro lado? ¿O qué es diferente entre este lugar y el resto?
- ¿Hay diferencias en los lugares u ocasiones donde es socialmente permitido tomar alcohol para hombres y no para mujeres o vice versa?

3. ¿Cuántas copas/vasos de trago toma usted normalmente en las ocasiones que usted toma?

   - Numero de tragos
   - Tipos de bebidas alcohólicas
   - ¿Hay diferencia entre hombres y mujeres? ¿Por qué?

4. ¿Cuáles son los momentos en los que ustedes no consumen alcohol, o en los que de acuerdo a sus costumbres ustedes no debieran consumir alcohol?

   - ¿Qué se hace en esos momentos que es distinto a cuando se toma alcohol?

5. ¿Que sería importante para ustedes que incluya una terapia que sea para disminuir el consumo en exceso?

   - ¿Quién debiera participar?
   - ¿Cuáles son las cosas que se debieran conversar?

Me gustaría conversar sobre cómo la gente a su alrededor influye en sus vidas.

6. ¿Qué personas son las más importantes en su vida?

   - prueba: amigos, familia, quienes?
   -(si ellos nombran "la familia" Que miembros de la familia? (si ellos no mencionan miembros de la familia) ¿Y qué pasa con la familia?

7. ¿Cómo influyen estas personas en lo que ustedes hacen o dejan de hacer?

   - ¿Me pueden dar algunos ejemplos? (prueba: siempre se conversan las cosas, me ayudan a decidir cuando tengo problemas, me prohíben que haga ciertas cosas, etc.).
   - ¿Qué DICEN O HACEN ESTAS PERSONAS en relación a su consumo de alcohol? Ejemplos acerca de lo que la familia dice y hace

8. ¿Qué áreas importantes de la vida se ven afectadas por el consumo de alcohol en exceso?

   -¿De qué manera?
   -¿Qué áreas son las más afectadas? ¿Por qué?

9. ¿Quiénes a su alrededor (o que instituciones importantes para ustedes) cuestionan o no están de acuerdo con el consumo excesivo de alcohol (actúan como reguladores externos del alcohol behavior)?

OFFICE OF RESEARCH SUPPORT

THE UNIVERSITY OF TEXAS AT AUSTIN

P.O. Box 7426, Austin, Texas 78713 · Mail Code A3200
(512) 471-8871 · FAX (512) 471-8873

FWA # 00002030

Date: 10/14/15

PI: Karla Gonzalez

Dept: Social Work, School of

Title: Cultural Adaptation of Solution Focused Brief Intervention for Individuals with Alcohol Use Disorders in Chile.

RE: Non-Human Subjects Research Determination

Dear Karla Gonzalez:

The Office of Research Support (ORS) reviewed the above protocol submission request and determined it did not meet the criteria for human subjects research as defined in the Common Rule (45 CFR 46) or FDA Regulations (21 CFR 56). IRB review and oversight is not required because the activities involve:

- ☐ No human interactions
- ☐ Classroom activities used to teach methodology and technique
- ☒ Program evaluation where results are not generalized to other services or programs
- ☐ Secondary use of de-identified data set (no direct or links to identifiers)
- ☐ Obtaining information that is not about living individuals
- ☐ Obtaining information from publicly available sets
- ☐ Biographical research that is not generalizable beyond the individual
- ☐ Archival research using existing literature
- ☐ Other (Explain):

At this time you are free to begin your research as IRB approval is not necessary. You should retain this letter with the respective research documents as evidence that IRB review and oversight is not required.

If you have any questions contact the ORS by phone at (512) 471-8871 or via e-mail at orsc@uts.cc.utexas.edu.

Sincerely,

James P. Wilson

James Wilson, Ph.D.
Institutional Review Board Chair

Appendix B: IRB Protocol for Pilot study Study Reported in Chapter 4.

1. Title

   Solution-focused brief intervention with alcohol users in Chile: a pilot study

2. Principal Investigator

   Karla Gonzalez, kg23857, Social Work

3. Purpose

The purpose of this study is to conduct a pilot testing of the cultural adaptation of solution-focused brief therapy (SFBT) by trained social workers. SFBT is a strengths-based, client-centered approach that evolved from the systemic approach, brief therapy, and family therapy. This approach is respectful and potentially applicable to Latinos because it considers not only individuals aspects, such as behavior or intrinsic motivations, but also their contexts and their interactions with significant others such as the family and the community to which the individuals belong (Corcoran, 2000; McNichols & Oliver, 2011). The target population of the intervention is low income individuals who use alcohol. To that end, four social workers will receive a 20 hours training in solution-focused brief therapy. Each social worker will implement the approach with five clients.

Chile has the highest average of alcohol consumption per capita in the American continent (north, central, and south) with 13.9% liters of alcohol for men and 5.5% for women, and one of the highest percentages of population with any alcohol use disorder (AUD; 8.5%) among Latin American countries (World Health Organization, 2014). These high levels of alcohol consumption are also associated with health and social outcomes, such as the highest alcohol attributable fraction to cirrhosis (over 66% for men and women) and 10% of deaths wholly attributable to alcohol, which means these percentages of cirrhosis and deaths would have not occurred if these people would have not consumed alcohol (Castillo-Carniglia, Kaufman, & Pino, 2013, World Health Organization, 2015). In addition to that, the last Chilean National Survey of Health (Encuesta Nacional de Salud 2009-2010) informed that 74% of the population 15 years and older consumed alcohol during the past year; 57% consumed alcohol during the past month; and 36% consumed alcohol during the past week. Among those who consumed alcohol during the past week, about 98% drank excessively (more than 20 grams of pure alcohol per day). In addition, the most part of Chilean population who had drank during the past year has had heavy drinking episodes, with an average of 55 grams in one day (Ministerio de Salud, 2011). More alarming is that those who had drank the week before consumed in average 88.40 grams of pure alcohol (103.66 for men; 60.46 for women; Ministerio de Salud, 2011).

SFBT is a relatively new approach and even though international literature does not provide us with robust evidence in terms of number of RCTs related to alcohol use disorders (like MI or CBT do), several studies in different cultures have provided positive outcomes (Cordero et al., 2009; De Schazer & Isebaert, 2004; Hendrick et al., 2012; Smock et al., 2008). In relation to the

implementers of this approach, it has been shown that BIs for alcohol use work successfully when implemented by non-medical practitioners (O'Donnell et al., 2014; Sullivan et al., 2011)., and it has also been suggested that social workers have a key role in working with individuals with alcohol use (Bliss & Pecukonis, 2009; Cochran & Field, 2013; Kotrla, 2005).

This study hypothesizes that:

1. Chilean social workers will adhere to the culturally adapted model of SFBT.
2. Clients who receive the culturally adapted intervention will adhere to it and will report decrease in alcohol patterns and problems or consequences associated to alcohol use.

4. Procedures

The training to social workers will consist in 20 hours provided in the School of Social Work of the Pontifical Catholic University, plus 10 hours of supervision per social worker provided at the work place of the social workers. A manual for the training will be a product of a first stage of the study based on the core elements that compound the SFBT approach.

The SFBT sessions will last between 40 and 60 minutes and consists of therapeutic encounters between a social worker and a client. During the session the social worker will implement the SFBT model to work with clients who present an alcohol use disorder. The model consists of a series of questions focused on the desired future, exceptions to the problem, and detailed description of both, desired future and exceptions to the problem. Towards the end of each session, the social worker will take a break to summarize strengths and useful information regarding the strategies that the client has already developed to provide a solution-focused feedback to the client and a suggestion (or homework) that usually consists of doing more of what works or observing when exceptions occur. First and subsequent sessions have the same structure. However, the second and third question will include what has worked well specifically during the period between the last session and the current, enhancing the exceptions and strategies that will help the client to reach his/her desired future.

It is expected to recruit 20 clients 18 years old and older. To check for fidelity of the implementation of the SFBT approach, sessions will be audio-taped and some of them will be video-taped. The fidelity of the model will be assessed by the Fidelity Instrument specially designed for SFBT (Lehmann & Patton, 2012), which consists of a check-list of activities. Video-recordings will be employed to assess the attitude and non-verbal language of the social workers, elements that are important in this model. Since the approach includes the possibility of direct supervision through one-way mirror, some sessions will be directly observed, however that action will occur depending on the schedule of the trainer (PI). Individuals will be informed an asked for consent when the session is supervised. The clients will meet the researcher only once before the beginning of the session, when they will be informed of the supervision.

Video and audio tapes of sessions will be stored in a hard drive for six months and will be observed and rated by the PI and other researcher trained in SFBT.

Since the main goal of this study is to test a program of brief intervention adapted to Chilean culture, the methodology of this research will consist on a single-case design with 20 replications. As such, the researcher will apply the same measures to 20 participants in repeated occasions in the aim of measuring baseline and evolution of each case during and after the intervention (Rubin and Bubble, 2005). This method seems to be the most adequate for a pilot study. An alternative methodology to the single-case design was the multiple-baseline design, which may provide a higher validity to this study. However, the multiple-baseline design conveys an ethical difficulty, because some subjects will need to wait more time for their treatment, which means that they may not receive the treatment on time. Therefore, and since the goal of the study is to evaluate the applicability of an intervention program in Chilean population, the methodology will be a single-case design. All participants will have a two-week baseline and will receive the same intervention after two weeks of their recruitment. The plan considers three observations for baseline, three observations during the intervention, and one observations one month after the end of the intervention.

d. Location

The setting of the interventions will be the primary clinic Juan Pablo II, located in Av. La Primavera 02870, La Pintana, and the primary clinic La Bandera, located in Calle Vicuña Mackenna 1758, San Ramón. Both in Santiago, Chile.

e. Resources

Offices of the clinics Juan Pablo II and La Bandera will be employed to:

- Recruit and invite the participants to the intervention.
- Apply measures.
- Supervise social workers.

The PI will provide the training at no cost.
Training sessions will be delivered in the School of Social Work at the Pontifical Catholic University of Chile (see Support Letter). There will be also direct supervision as part of the training, which will occur at the clinics.

f. Study Timeline

Training will occur between January and March, 2016 and interventions and data collection will occur between February and May, 2016. Analysis and dissemination of results will occur between April and November 2016.

5. Measures

- Background information (control variables). Age, gender, partner status, educational attainment, income, and job status will be measured at baseline (Estimated time for application 5 minutes).
- AUDIT. The Alcohol Use Disorders Identification Test is a widely used instrument that is validated in Chile and is currently used in primary care to assess for several alcohol use

disorders (Babor et al., 2001). This test will be the screening tool used to identify potential participants during the recruitment process (Estimated time for application 5 minutes).

- ASSIST. The Alcohol Smoking and Substance Involvement Screening is an instrument to assess at-risk substance use and is recommended for use in primary care by the WHO, and by the SENDA in Chile (Estimated time for application 5 - 15 minutes, depending on how many substances the client uses).
- TLFB. The Time line follow-back is calendar that measures quantity and frequency of alcohol use during the past year (Sobell & Sobell, 1992). The TLFB method has been shown to be valid and reliable and is a more time- and cost-effective method that more involved procedures like blood testing (Estimated time for application 10-20 minutes).
- Self-monitoring sheets. This is a calendar used to measure the daily quantity and frequency of alcohol use, from the beginning of the intervention until its end. Individuals will be asked to fill out the days that they use alcohol, providing the quantity and frequency of alcohol they consumed (Sobell & Sobell, 1992; (Estimated time for application 2-5 minutes at home).
- SIP. The Short inventory of problems measures five dimensions of drinking consequences. It has been validated with Spanish-speaking populations (Marra, Field, Caetano & von Sternberg, 2014; Estimated time for application 10-15 minutes).
- Patient Health Questionnaire (PHQ-9). This is a self-administered instrument that was designed to be employed in primary care and corresponds to the depression module of the PRIME-MD, a tool for identifying several mental health disorders (Kroenke, Spitzer, & Williams, 2001; (Estimated time for application 5-10 minutes).
- Family Health (*Salud Familiar*; SALUFAM). This is a 13-item screening instrument that was built using questions from several instruments assessing familial aspects such as agreement, cohesiveness, emotional expressions, conflict, commitment, trust, social support, labor stressors, familial stressors, and health stressors, by a Chilean team (Puschel, Repeto, Solar, Soto, & Gonzalez, 2012; (Estimated time for application 5-10 minutes)).
- Solution-focused fidelity instrument. To check for fidelity of the implementation of the SFBT approach by trained social workers, the interventions will be audio-recorded and analyzed by the PI and another practitioner expert in SFBT independently. To this end, the translated version of the Solution-Focused Fidelity Instrument (Lehmann and Patton, 2012; (Estimated time for self-application 5 minutes; and external application the length of the session).
- Outcome Rating Scale (ORS). This 4-item survey gathers information about four areas of individuals' lives. This instrument can be applied at the beginning of each session and serves to establish therapeutic goals and challenges in each area (Duncan et al., 2003; Estimated time for application 2 minutes).
- Session Rating Scale (SRS). This 4-item survey is an opportunity to evaluate the session and the therapeutic relationship. It is applied at the end of the session and has a visual scale in which the client assesses the performance of the therapist (Duncan et al., 2003; Estimated time for application 2 minutes).

6. Participants
    a. Target Population

        Target population will be about 20 men and/or women 18 years old or older who are patients to the CESFAM Juan Pablo II, and who have been identified as presenting any alcohol use disorder as measured by the AUDIT. Results of this study will inform future

research in social work, primary care, and alcohol use disorders that will be useful for creating programs and policy in Chile and the rest of Latin America.

b. Inclusion/Exclusion

To participate in this study, individuals must be:

- Between 18 and 65 years old
- Able to verbally communicate with others
- Willing to participate in the intervention
- Willing to fill measures forms

Individuals will be excluded if:

- Present a severe and not treated mental illness such as schizophrenia
- Are not willing to participate in the intervention
- Are not willing to fill measures forms

c. Benefits

The clients will receive a culturally adapted intervention for alcohol use that has been shown to be efficacious in other countries. This intervention has also been useful for improving other life aspects such as mental health. Therefore, the individuals who participate in this study could decrease their average alcohol intake and improve other aspects of their lives. This is the first research that examines a culturally adapted brief intervention for alcohol use disorders in primary care. In addition, this is the first research that examines the feasibility of SFBT, implemented by social workers in Chile.

d. Risks

The risks to which individuals participating in this study are exposed are not greater than to the risks that an individual is exposed when receiving mental health services in primary care and are mainly associated to mainly three aspects: confidentiality, privacy, and mental health wellbeing.

In regards to confidentiality, the patient information will be carefully kept in the clinic records and all forms for measures will be identified with a number that will replace client's name in a folder that only the research team will have access. This forms will be stored in the office of the PI located in the School of Social Work in the Pontifical Catholic University in a locked files storage The information contained in these forms will be transcribed to a data analysis program such as SPSS or other to be analyzed. The clinical records of the patients will not be consulted and will not form part of this research.

In relation to privacy, it is likely that the patients share private aspects of their life during therapy. These private aspects will be audio or video-taped and will not be used for any end. The contents of the sessions will only be used to analyze the techniques that the social workers put in practice and to examine the fidelity that social workers keep with the approach. As the context of the intervention is primary care, some aspects of the

session's contents may be recorded in the patient´s medical records. However, the research team will not have access to those records and will not ask for them.
In regards to the mental health wellbeing, because the solution-focused brief approach is focused on positive and future life situations, the risk of causing any mental health damage is widely diminished. Should an individual feel distressed or uncomfortable during an intervention session, a plan to provide the individual with contention and crisis intervention in the clinic or in other service will be available. The PI will be also available to accompany the individual to any facility that may be needed.

e. Recruitment
The potential participants of this study will be recruited through three strategies: Firstly, the researcher will receive referrals form the medical or paramedical personnel who detects any AUD as measured by the AUDIT (part of the preventive examination undertaken regularly in the clinic). Patients who obtain a score equal or higher than 8 will be put in contact with the PI and she will inform them of the study and invite them to participate. Secondly, self-referrals from individuals in the community who have heard of the research project through flyers, and signboards. Thirdly, snowball from patients who self-refer because someone who they know told them about the project. Once a potential participant is identified, he or she will be referred with the PI, who will provide the participant with information of the study and check for eligibility (seethe appendix Script for Recruitment for detailed information of this process).

f. Obtaining Informed Consent
Each time a patient is referred, the PI will contact the potential participant and call him/her for a meeting to invite him/her to the project. The potential participant will be informed of his/her rights and will be provided with a brief description of the project at the moment of the interview. Additionally, a written Informed Consent will be provided and read before completing the measure forms.Since the participants' language is Spanish, the Informed Consent will be in Spanish. The PI is Chilean and her native language is Spanish, thus she has made sure the language employed in the IC is accurate and understandable.

7. Privacy and Confidentiality

The participants will be informed and asked for authorization to audio or video-tape their sessions through the informed consent and will be reminded of this before each of the sessions. The audio and video-taped sessions will be stored in a hard drive for six months, they will be identified with a number and no patient's information will be associated to the video-tapes.
The records related to the measures and forms will be stored in a key protected hard drive with no patient identification. Only a number and code regarding the clinic will be assigned to each participant for research purposes. Since this study will set the basis for subsequent studies, the data will be kept for 10 years. The documents such as informed consent forms, and measure forms will be destroyed after one year.

Any research assistant or research member who may have access to confidential or private information will sign a "Confidentiality Agreement" as a compromise to respect confidentiality and privacy of the contents and identification of participants (see appendix).

8. Compensation

A compensation for participate in the focus groups will be given to the participants. This will be 3.000 Chilean pesos (about 5 dollars) for attending to fill out the measures forms.

9. International Research

This study will be conducted in Chile. The researcher is a Chilean social worker and her interest in brief interventions in health settings that serve vulnerable populations. The researcher worked for 10 years as a social worker in her country. The latter six years devoted her practice to the CESFAM Juan Pablo II in which she will implement this study whereas before that, she assisted families who lived close to the CESFAM La Bandera. In addition, her comprehensive examination during her doctoral studies was on brief interventions for alcohol use in Latin America, where her main focus was the policy, programs and practice around this topic in Chile. The Health Service from which these clinics receive supervision requires that the study is reviewed by the Ethics Committee of the Metropolitan South-East Health Service. In addition, Since the CESFAM Juan Pablo II is administrated by the Pontifical Catholic University of Chile, the study requires the approval of the local IRB of this institution. Both protocols are attached in this application.

The PI will communicate with the University IRB for continuing review, amendments, unanticipated problems, complaints, etc, via email to the IRB Program Coordinator, Julio Fonseca j.fonseca@austin.utexas.edu or via another email that the Office of Research Support indicates.

The PI and the Faculty Sponsor, Dr Cynthia Franklin, will have online meetings via Skype twice a month to supervise the conduct of the study. In addition, email communication and extra Skype meetings will occur if needed.

BACKGROUND INFORMATION: Thank you very much for taking a time to answer this questionnaire. Please, answer honestly all the questions. THIS QUESTIONNAIRE IS ANONIMOUS.

2. How old are you?_____

Please, mark with an X

3. Male _____ Woman _____
4. Do you have a partner? Yes _____ No____
5. Do you live with her/him?
6. Which was the last grade you attended in school?
    a. Less than 8° elementary
    b. 8° elementary
    c. Between 1° and 3° high school
    d. 4° High school
    e. Tech or university incomplete
    f. Tech or university complete
    g. Post graduate
7. Mark the alternative that best represents your family income:
    a. Between 0 and 100.000 CLP
    b. Between 100.001 and 200.000 CLP
    c. Between 200.001 and 300.000 CLP
    d. Between 300.001 and 400.000 CLP
    e. Between 400.001 and 500.000 CLP
    f. Between 500.001 and 600.000 CLP
    g. More than 600.001 CLP
8. How many people live with this income? _____
9. Are you working right now? Please mark the alternative that best represents your job status.
    a. No
    b. Yes, independent
    c. Yes, with a contract
    d. Part-time job
    e. Full-time job

PHQ-9

10. Now, we want to ask you about your general health. Please mark 0 if your answer is not at all, 1 if your answer is several days, 2 if your answer is more than half the days, and 3 if your answer is nearly every day.

Over the last 2 weeks, how often have you been bothered by any of the following problems?		*Not at all*	*Several days*	*More than half the days*	*Nearly every day*
1	Little interest or pleasure in doing things	*0*	*1*	*2*	*3*
2	Feeling down, depressed, or hopeless	*0*	*1*	*2*	*3*
3	Trouble falling or staying asleep, or sleeping too much	*0*	*1*	*2*	*3*
4	Feeling tired or having little energy	*0*	*1*	*2*	*3*
5	Poor appetite or overeating	*0*	*1*	*2*	*3*
6	Feeling bad about yourself or that you are a failure or have let yourself or your family down	*0*	*1*	*2*	*3*
7	Trouble concentrating on things, such as reading the newspaper or watching television	*0*	*1*	*2*	*3*
8	Moving or speaking so slowly that other people could have noticed. Or the opposite being so figety or restless that you have been moving around a lot more than usual	*0*	*1*	*2*	*3*
9	Thoughts that you would be better off dead, or of hurting yourself	*0*	*1*	*2*	*3*

If you checked off any problems, how difficult Not difficult at all have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

FAMILY HEALTH

11. Now, we want to ask you about how your family is. Please, mark 1 if your answer is never, 2 if your answer is few rimes, 3, if your answer is sometimes, 4 if your answer is a lot of times, and 5 if your answer is always. Please mark the alternative that represent the most as your family is. (this questionnaire is originally in Spanish, and the translation to English was done by the author of the proposal.)

	Questions:	Never	Few times	sometimes	A lot of times	Always	Do not know
1	We agree on how family members must behave	1	2	3	4	5	0
2	We agree on things that are important to our family	1	2	3	4	5	0
3	We know what we want to achieve as a family in the future	1	2	3	4	5	0
4	We attempt to see the positive side of things	1	2	3	4	5	0
5	We attempt to forget our problems for a period of time when they seem unbeatable	1	2	3	4	5	0
6	When there is a problema, we are able to see the positive and negative aspects	1	2	3	4	5	0
7	Each of us in the family is able to listen the two versions of a story	1	2	3	4	5	0
8	In our family we have at least one day in which we do something together	1	2	3	4	5	0
9	We can ask for help to someone outside of the family if we need it	1	2	3	4	5	0
10	We can trust in others' support when something goes wrong	1	2	3	4	5	0
11	Our friends and relatives like to visit us	1	2	3	4	5	0
12	We do an effort to help our relatives when they need it	1	2	3	4	5	0
13	Our friends and relatives will help us if we need it	1	2	3	4	5	0

SHORT INVENTORY OF PROBLEMS (SIP)

12. Here, there is a number of situations that people who drink or who use drugs experience sometimes. Please read carefully and indicate how often have happened to you each of these situations in the last three months (or the last month for the follow up) Never, few times, sometimes, a lot of times, and always.

	Questions	Nunca	Pocas veces	Algunas veces	Muchas veces	Siempre
1	I have been unhappy because of my drinking	1	2	3	4	5
2	Because of my drinking, I have not eaten properly	1	2	3	4	5
3	I have failed to do what is expected of me because of my drinking	1	2	3	4	5
4	I have felt guilty or ashamed because of my drinking	1	2	3	4	5
5	I have taken foolish risks when I have been drinking	1	2	3	4	5
6	When drinking, I have done impulsive things that I regretted later.	1	2	3	4	5
7	My physical health has been harmed by my drinking	1	2	3	4	5
8	I have had money problems because of my drinking	1	2	3	4	5
9	My physical appearance has been harmed by my drinking	1	2	3	4	5
10	My family has been hurt by my drinking	1	2	3	4	5

11	A friendship or close relationship has been damaged by my drinking.	1	2	3	4	5
12	A friendship or close relationship has been damaged by my drinking.	1	2	3	4	5
13	My drinking has gotten in the way of my growth as a person	1	2	3	4	5
14	My drinking has damaged my social life, popularity or reputation.	1	2	3	4	5
15	I have spent too much or lost a lot of money because of my drinking	1	2	3	4	5

ASSIST

13. Instrument applied by a member of the research team.

Question 1

In your life, which of the following substances have you In your life, which of the following substances have you ever used? (NON-MEDICAL U MEDICAL U MEDICAL USE ONLY)		NO	YES
a.	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b.	Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c.	Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d.	Cocaine (coke, crack, etc.)	0	3
e.	Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f.	Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g.	Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h.	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i.	Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j.	Other - specify:	0	3

Probe if all answers are negative: Probe if all answers are negative: “Not even when you were in school?” “Not even when you were in school?” If "No" to all items, stop

interview. If "Yes" to any of these items, ask Question If "Yes" to any of these items, ask Question 2 for each substance ever used.

Pregunta 2

In the past three months In the past three months, how often have you used , how often have you used the substances you mentioned (FIRST DRUG, (FIRST DRUG, SECOND DRUG, ETC)?		Never	One or twice	Monthly	Weekly	Dayly or Alcmst always
a.	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b.	Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c.	Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d.	Cocaine (coke, crack, etc.)	0	2	3	4	6
e.	Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f.	Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g.	Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h.	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i.	Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j.	Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6. If any substances in Question 2 were used in the previous three months, continue with If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substanc Questions 3, 4 & 5 for each substanc each substance used.

Question 3

During the past three months During the past three months, how often have you , how often have you had a strong desire or urge to use (FIRST DRUG, SECOND DRUG, ETC)?		Never	One or twice	Monthly	Weekly	Dayly or Alcmst
a.	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6

b.	Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c.	Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d.	Cocaine (coke, crack, etc.)	0	3	4	5	6
e.	Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f.	Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g.	Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h.	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i.	Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j.	Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your , how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?		Never	One or twice	Monthly	Weekly	Dayly or Alcmst
a.	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b.	Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c.	Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d.	Cocaine (coke, crack, etc.)	0	4	5	6	7
e.	Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f.	Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g.	Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h.	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i.	Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j.	Other - specify:	0	4	5	6	7

Pregunta 5

During the past three months During the past three months, how often have you failed , how often have you failed to do what was normally expected of you because of to do what was normally expected of you because of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)?		Never	One or twice	Monthly	Weekly	Dayly or Alcmst always
a.	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)					
b.	Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c.	Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d.	Cocaine (coke, crack, etc.)	0	5	6	7	8
e.	Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f.	Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g.	Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h.	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i.	Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j.	Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.)?		No, Never	Yes, in the past three	Yes, but not in the past three months
a.	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b.	Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c.	Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d.	Cocaine (coke, crack, etc.)	0	6	3

e.	Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f.	Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g.	Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h.	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i.	Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j.	Other - specify:	0	6	3

Pregunta 7

Have you ever tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC.)?		No,	Yes, in the past three months meses	Yes, but not in the past three months
a.	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b.	Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c.	Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d.	Cocaine (coke, crack, etc.)	0	6	3
e.	Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f.	Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g.	Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h.	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i.	Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j.	Other - specify:	0	6	3

Pregunta 8

Have you ever Have you ever used any drug by injection? used any drug by injection? (NON-MEDICAL USE ONLY)	No, Never	Yes, in the past three months	Yes, but not in the past three months
	0	2	1

Time-line follow-back

14. Please, mark on the calendar the dates in the last 12 months in which you have drank alcohol. Then in the reverse of this page, write down of the dates and amount of cups and the type of beverage you drank.

Calendario 2015

Enero

Lu	Ma	Mi	Ju	Vi	Sa	Do
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Febrero

Lu	Ma	Mi	Ju	Vi	Sa	Do
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

Marzo

Lu	Ma	Mi	Ju	Vi	Sa	Do
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Abril

Lu	Ma	Mi	Ju	Vi	Sa	Do
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Mayo

Lu	Ma	Mi	Ju	Vi	Sa	Do
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Junio

Lu	Ma	Mi	Ju	Vi	Sa	Do
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Julio

Lu	Ma	Mi	Ju	Vi	Sa	Do
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Agosto

Lu	Ma	Mi	Ju	Vi	Sa	Do
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Septiembre

Lu	Ma	Mi	Ju	Vi	Sa	Do
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Octubre

Lu	Ma	Mi	Ju	Vi	Sa	Do
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Noviembre

Lu	Ma	Mi	Ju	Vi	Sa	Do
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

Diciembre

Lu	Ma	Mi	Ju	Vi	Sa	Do
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Calendario 2016

Enero

Lu	Ma	Mi	Ju	Vi	Sa	Do
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Febrero

Lu	Ma	Mi	Ju	Vi	Sa	Do
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

Marzo

Lu	Ma	Mi	Ju	Vi	Sa	Do
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Abril

Lu	Ma	Mi	Ju	Vi	Sa	Do
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

Back TIME LINE FOLLOW BACK

Please write down of the date and then the type of beverage that you drank and the amount of drinks. If you drank different types of beverages in the same date, please write down again the same date and provide details of the type of beverage and amount of cups.

Date	Type of Beverage	Amount of cups

Outcome Rating Scale (ORS)

Name _____Age (Yrs):____
Session # ____ Date: _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I


Interpersonally
(Family, close relationships)

I----------I


Socially
(Work, school, friendships)

I----------I


Overall
(General sense of well-being)

I----------I


Muchas gracias por darse el tiempo para responder este cuestionario. Por favor, responda lo más sinceramente que pueda a todas las preguntas. ESTE CUESTIONARIO ES ANÓNIMO

Información de antecedentes demográficos

2. ¿Qué edad tiene usted _____

Por favor, marque con una X

3. Hombre _____ Mujer _____
4. ¿Tiene usted pareja? SI _____ NO____
5. ¿Vive usted con él o ella? SI _____ NO____
6. ¿Hasta qué curso llegó?
    h. Menos que 8° básico
    i. 8° básio
    j. Entre 1° y 3° de enseñanza media
    k. 4° medio
    l. Técnico o Universitario incompleto
    m. Técnico o Universitario completo
    n. Post grado
7. Marque la alternative que mejor represente sus ingresos:
    a. Entre 0 y 100.000 pesos
    b. Entre 100.001 y 200.000 pesos
    c. Entre 200.001 y 300.000 pesos
    d. Entre 300.001 y 400.000 pesos
    e. Entre 400.001 y 500.000 pesos
    f. Entre 500.001 y 600.000 pesos
    g. Más de 600.001 pesos
8. ¿Cuántas personas viven con ese ingreso?
9. ¿Está trabajando ahora? Por favor, marque las alternativas que mejor represente su situación laboral.
    a. No
    b. Si, independiente
    c. Si, con contrato
    d. Media jornada
    e. Jornada completa
10. Ahora queremos preguntarle acerca de su salud en general. Marque 0 si su respuesta es No del todo, 1 si su respuesta es varios días, 2 si su respuesta es más de la mitad de los días y 3 si su respuesta es casi todos los días. Por favor, marque la alternativa que más lo identifique en relación a las últimas DOS SEMANAS.

Cuestionario de Salud del Paciente (PHQ-9)

11. ***Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias por cualquiera de las siguientes dificultades?***		*No del todo*	*Varios días*	*Más de la mitad de los días*	*Casi todos los días*
1	Poco interés o placer en hacer cosas	*0*	*1*	*2*	*3*
2	Sintiéndose decaído(a), deprimido(a), o sin esperanzas	*0*	*1*	*2*	*3*
3	Dificultad en caer o permanecer dormido(a), o dormir demasiado	*0*	*1*	*2*	*3*
4	Sintiéndose cansado o teniendo poca energía	*0*	*1*	*2*	*3*
5	Pobre de apetito o comer en exceso	*0*	*1*	*2*	*3*
6	Sintiéndose mal con usted mismo(a) – o que usted es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	*0*	*1*	*2*	*3*
7	Dificultad en concentrarse en cosas, tales como leer el periódico o ver televisión	*0*	*1*	*2*	*3*
8	¿Moviéndose o hablando tan lento, que otras personas podrían notarlo? O lo contrario – muy inquieto(a) o agitado(a) que usted ha estado moviéndose mucho más de lo normal	*0*	*1*	*2*	*3*
9	Pensamientos de que usted estaría mejor muerto(a) o de alguna manera lastimándose a usted mismo(a)	*0*	*1*	*2*	*3*

Si usted marcó cualquiera de los problemas, ¿qué tan difícil han afectado estos problemas en hacer su trabajo, encargarse de tareas del hogar, o llevarse bien con otras personas?

Para nada difícil	Un poco difícil	Muy difícil	Extremadamente difícil

Salud de la Familia (SALUFAM)

12. Ahora queremos preguntarle acerca de **cómo es su familia**. Por favor marque 1 si su respuesta es nunca, 2 si su respuesta es pocas veces, 3 si su respuesta es algunas veces, 4 si su respuesta es muchas veces, 5 si su respuesta es siempre y 0 si usted no sabe. Por favor marque la alternativa que más represente como es su familia.

	Pregunta	Nunca	Pocas veces	Algunas veces	Muchas veces	Siempre	No Sabe
1	Estamos de acuerdo en cómo deben actuar los miembros de nuestra familia	1	2	3	4	5	0
2	Estamos de acuerdo en las cosas que son importantes para nuestra familia	1	2	3	4	5	0
3	Sabemos qué queremos lograr como familia en el futuro	1	2	3	4	5	0
4	Intentamos mirar el lado positivo de las cosas	1	2	3	4	5	0
5	Intentamos olvidar nuestros problemas por un tiempo cuando parece que son insuperables	1	2	3	4	5	0
6	Cuando hay un problema logramos ver los aspectos positivos y negativos	1	2	3	4	5	0
7	Cada uno de nosotros en la familia es capaz de escuchar las dos versiones de una historia	1	2	3	4	5	0
8	En nuestra familia tenemos al menos un día en que realizamos alguna actividad todos juntos	1	2	3	4	5	0
9	Podemos pedir ayuda a alguien de afuera de la familia si lo necesitamos	1	2	3	4	5	0
10	Podemos confiar en el apoyo de los demás cuando algo va mal	1	2	3	4	5	0
11	A nuestros amigos o familiares les gusta visitarnos	1	2	3	4	5	0
12	Hacemos un esfuerzo por ayudar a nuestros parientes cuando lo necesitan	1	2	3	4	5	0

13	Nuestros amigos y familiares nos ayudarán si lo necesitamos	1	2	3	4	5	0

Inventario Breve de Problemas (SIP)

13. Aquí hay un número de situaciones que los bebedores o los que usan drogas experimentan algunas veces. Lea cada uno cuidadosamente e indique que tan a menudo le ha ocurrido cada uno a usted durante los últimos 3 meses (Nunca, Una vez o Unas pocas veces, etc.). Si uno de los puntos no le aplica, marque 'Nunca'.

	Pregunta	Nunca	Pocas veces	Algunas veces	Muchas veces	Siempre
1	He estado infeliz por consumir (tomar, usar) bebidas o drogas	1	2	3	4	5
2	Por consumir (tomar, usar) bebidas o drogas, he perdido peso o no he comido apropiadamente	1	2	3	4	5
3	He fallado en hacer lo que se espera de mí, por consumir (tomar, usar) bebidas o drogas	1	2	3	4	5
4	Me he sentido culpable o avergonzado(a) (pena) por consumir (tomar, usar) bebidas o drogas	1	2	3	4	5
5	He tomado riesgos tontos cuando he estado bebiendo (tomando) o usando drogas	1	2	3	4	5
6	Cuando he estado bebiendo (tomando) o usando drogas, he hecho cosas impulsivas que he lamentado más tarde	1	2	3	4	5
7	El beber (tomar) o el usar una droga me ha causado usar otras drogas	1	2	3	4	5
8	Mi salud física se ha dañado por consumir (tomar, usar) bebidas o drogas	1	2	3	4	5
9	He tenido problemas de dinero por consumir (tomar, usar) bebidas o drogas.	1	2	3	4	5
10	Mi apariencia física se ha dañado por consumir (tomar, usar) bebidas o drogas.	1	2	3	4	5
11	Mi familia se ha lastimado (herido) por consumir (tomar, usar) bebidas o drogas.	1	2	3	4	5
12	Una amistad o una relación cercana se ha dañado por consumir (tomar, usar) bebidas o drogas.	1	2	3	4	5
13	Mi beber (tomar) o uso de droga se ha metido en el camino de mi crecimiento como persona.	1	2	3	4	5

14	Mi beber (tomar) o uso de droga ha dañado mi vida social, mi popularidad, o mi reputación.	1	2	3	4	5
15	He gastado mucho o perdido mucho dinero por consumir (tomar, usar) bebidas o drogas.	1	2	3	4	5

Test de Screening para el uso de alcohol, tabaco, y otras substancias (ASSIST).

*****Aplicado por un miembro del equipo investigador*****

Entregar tarjetas de respuesta a los participantes

Pregunta 1

A lo largo de su vida, ¿cual de las siguientes sustancias ha consumido alguna vez? (SOLO PARA USOS NO-MÉDICOS)		NO	SI
k.	Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	3
l.	Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	3
m.	Cannabis (marihuana, costo, hierba, hashish, etc.)	0	3
n.	Cocaína (coca, farlopa, crack, base, etc.)	0	3
o.	Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	3
p.	Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	3
q.	Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	3
r.	Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	3
s.	Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	3
t.	Otros - especifique:	0	3

Compruebe si todas las respuestas son negativas: "¿Tampoco incluso cuando iba al colegio?" Si contestó "No" a todos los ítems, pare la entrevista. Si contestó "Si" a alguno de estos ítems, siga a la Pregunta 2 para cada sustancia que ha consumido alguna vez.

Pregunta 2

¿Con qué frecuencia ha consumido las sustancias que ha mencionado en los últimos tres meses, (PRIMERA DROGA, SEGUNDA DROGA, ETC)?		Nunca	1 o 2 veces	Cada	Cada semana	A diario o casi a
k.	Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	2	3	4	6
l.	Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	2	3	4	6

m.	Cannabis (marihuana, costo, hierba, hashish, etc.)	0	2	3	4	6
n.	Cocaína (coca, farlopa, crack, base, etc.)	0	2	3	4	6

Continuación ASSIST

o.	Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	2	3	4	6
p.	Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	2	3	4	6
q.	Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	2	3	4	6
r.	Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	2	3	4	6
s.	Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	2	3	4	6
t.	Otros - especifique:	0	2	3	4	6

Si ha respondido "Nunca" a todos los items en la Pregunta 2, salte a la Pregunta 6. Si ha consumido alguna de las sustancias de la Pregunta 2 en los últimos tres meses, continúe con las preguntas 3, 4 & 5 para cada una de las sustancias que ha consumido.

Pregunta 3

En los últimos tres meses, ¿con qué frecuencia ha tenido deseos fuertes o ansias de consumir (PRIMERA DROGA, SEGUNDA DROGA, ETC)?		Nunca	1 o 2 veces	Cada	Cada semana	A diario o casi a
k.	Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	3	4	5	6
l.	Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	3	4	5	6
m.	Cannabis (marihuana, costo, hierba, hashish, etc.)	0	3	4	5	6
n.	Cocaína (coca, farlopa, crack, base, etc.)	0	3	4	5	6
o.	Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	3	4	5	6
p.	Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	3	4	5	6

q.	Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	3	4	5	6
r.	Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	3	4	5	6

Continuación ASSIST

s.	Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	3	4	5	6
t.	Otros - especifique:	0	3	4	5	6

Pregunta 4

En los últimos tres meses, ¿con qué frecuencia le ha llevado su consumo de (PRIMERA DROGA, SEGUNDA DROGA, ETC) a problemas de salud, sociales, legales o económicos?		Nunca	1 o 2 veces	Cada mes	Cada semana	A diario o casi a
k.	Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	4	5	6	7
l.	Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	4	5	6	7
m.	Cannabis (marihuana, costo, hierba, hashish, etc.)	0	4	5	6	7
n.	Cocaína (coca, farlopa, crack, base, etc.)	0	4	5	6	7
o.	Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	4	5	6	7
p.	Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	4	5	6	7
q.	Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	4	5	6	7
r.	Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	4	5	6	7
s.	Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	4	5	6	7
t.	Otros - especifique:	0	4	5	6	7

Pregunta 5

En los últimos tres meses, ¿con qué frecuencia dejó de hacer lo que se esperaba de usted habitualmente por el consumo de (PRIMERA DROGA, SEGUNDA DROGA, ETC)?		Nunca	1 o 2 veces	Cada mes	Cada semana	A diario o casi a
k.	Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)					

Continuación ASSIST

l.	Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	5	6	7	8
m.	Cannabis (marihuana, costo, hierba, hashish, etc.)	0	5	6	7	8
n.	Cocaína (coca, farlopa, crack, base, etc.)	0	5	6	7	8
o.	Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	5	6	7	8
p.	Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	5	6	7	8
q.	Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	5	6	7	8
r.	Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	5	6	7	8
s.	Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	5	6	7	8
t.	Otros - especifique:	0	5	6	7	8

Haga las preguntas 6 y 7 para todas las sustancias que ha consumido alguna vez (es decir, aquellas abordadas en la Pregunta 1)

Pregunta 6

¿Un amigo, un familiar o alguien más alguna vez ha mostrado preocupación por su consume de (PRIMERA DROGA, SEGUNDA DROGA, ETC)?		No, Nunca	Si, en los últimos 3 meses	Si, pero no en los últimos 3 meses
k.	Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	6	3
l.	Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	6	3
m.	Cannabis (marihuana, costo, hierba, hashish, etc.)	0	6	3

n.	Cocaína (coca, farlopa, crack, base, etc.)	0	6	3
o.	Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	6	3
p.	Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	6	3

Continuación ASSIST

q.	Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	6	3
r.	Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	6	3
s.	Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	6	3
t.	Otros - especifique:	0	6	3

Pregunta 7

¿Ha intentado alguna vez controlar, reducir o dejar de consumir (PRIMERA DROGA, SEGUNDA DROGA, ETC) y no lo ha logrado?		No, Nunca	Si, en los últimos 3 meses	Si, pero no en los últimos 3 meses
u.	Tabaco (cigarrillos, cigarros habanos, tabaco de mascar, pipa, etc.)	0	6	3
v.	Bebidas alcohólicas (cerveza, vino, licores, destilados, etc.)	0	6	3
w.	Cannabis (marihuana, costo, hierba, hashish, etc.)	0	6	3
x.	Cocaína (coca, farlopa, crack, base, etc.)	0	6	3
y.	Anfetaminas u otro tipo de estimulantes (speed, éxtasis, píldoras adelgazantes, etc.)	0	6	3
z.	Inhalantes (colas, gasolina/nafta, pegamento, etc.)	0	6	3
aa.	Tranquilizantes o pastillas para dormir (valium/diazepam, Trankimazin/Alprazolam/Xanax, Orfidal/Lorazepam, Rohipnol, etc.)	0	6	3
bb.	Alucinógenos (LSD, ácidos, ketamina, PCP, etc.)	0	6	3
cc.	Opiáceos (heroína, metadona, codeína, morfina, dolantina/petidina, etc.)	0	6	3

dd.	Otros - especifique:	0	6	3

Pregunta 8

¿Ha consumido alguna vez alguna droga por vía inyectada? (ÚNICAMENTE PARA USOS NO MÉDICOS)	No, Nunca	Si, en los últimos 3 meses	Si, pero no en los últimos 3 meses
	0	2	1

<u>Línea de Base Retrospectiva LIBARE (TLFB)</u>

Por favor, marque en el calendario, las fechas en los últimos 12 meses en que usted ha bebido alcohol. Luego en el reverso de esta página, anote las fechas y la cantidad de copas o vasos y el tipo de trago que bebió.

Calendario 2015

Enero

Lu	Ma	Mi	Ju	Vi	Sa	Do
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Febrero

Lu	Ma	Mi	Ju	Vi	Sa	Do
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

Marzo

Lu	Ma	Mi	Ju	Vi	Sa	Do
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Abril

Lu	Ma	Mi	Ju	Vi	Sa	Do
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Mayo

Lu	Ma	Mi	Ju	Vi	Sa	Do
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Junio

Lu	Ma	Mi	Ju	Vi	Sa	Do
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Julio

Lu	Ma	Mi	Ju	Vi	Sa	Do
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

Agosto

Lu	Ma	Mi	Ju	Vi	Sa	Do
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Septiembre

Lu	Ma	Mi	Ju	Vi	Sa	Do
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Octubre

Lu	Ma	Mi	Ju	Vi	Sa	Do
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Noviembre

Lu	Ma	Mi	Ju	Vi	Sa	Do
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

Diciembre

Lu	Ma	Mi	Ju	Vi	Sa	Do
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Calendario 2016

Enero

Lu	Ma	Mi	Ju	Vi	Sa	Do
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Febrero

Lu	Ma	Mi	Ju	Vi	Sa	Do
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

Marzo

Lu	Ma	Mi	Ju	Vi	Sa	Do
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Abril

Lu	Ma	Mi	Ju	Vi	Sa	Do
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

Reverso LIBARE

Anote la fecha y luego el tipo de trago que bebió junto con la cantidad de copas. Si bebió distintos tipos de trago en una misma fecha, anote nuevamente la misma fecha y detalle el tipo de trago y cantidad de copas.

Fecha	Tipo de Trago	Cantidad de vasos o copas

Encuesta de Resultados

Nombre _____ Edad (Años):____

Cita #____ Fecha: _____

Pensando sobre la semana pasada, incluyendo hoy, ayúdenos a entender cómo se ha estado sintiendo en las áreas de vida incluidas en esta encuesta. Marcas a la izquierda representan niveles bajos y marcas a la derecha representan niveles altos.

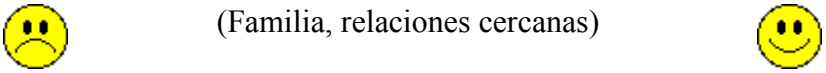
Individualmente:

(Bienestar personal)

I----------I

Con otras personas:

(Familia, relaciones cercanas)



I----------I

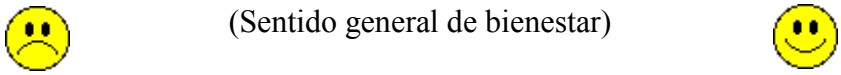
Socialmente:

(Trabajo, Escuela, Amistades)

I----------I

Global (en general):

(Sentido general de bienestar)



I----------I

Fidelity instrument SFBT/ Instrumento de fidelidad TBCS

1	I asked what the client wanted out of today's session.	Pregunté qué es lo que el consultante quería de la sesión de hoy.
2	I asked "what's better" in today's session.	Pregunté qué está mejor en la sesión de hoy.
3	The client's stated needs for today's session were related to overall goal(s) for therapy.	Las necesidades que el cliente planteó para la sesión de hoy estuvieron relacionadas con los objetivos generales de la terapia.
4	I summarized the client's comments during today's session.	Hice un resumen de los comentarios del consultante durante la sesión.
5	I complimented the client's strengths/resources during today's session.	Felicité las fortalezas y recursos del consultante durante la sesión.
6	I asked exception/difference questions during today's session.	Pregunté por excepciones o preguntas acerca de diferencia durante la sesión de hoy.
7	I asked amplifying questions during today's session.	Hice preguntas ampliadoras durante la sesión de hoy.
8	I asked reinforcing questions (e.g., summarizing/complimenting) of the client's reported change in today's session.	Hice preguntas reforzadoras (resumen, felicitaciones) de los cambios reportados por el consultante durante la sesión de hoy.
9	I was able to help the client behaviorally describe a next small step of progress.	Fui capaz de hacer que el consultante describa en términos de comportamiento un próximo pequeño paso de progreso.
10	I asked scaling questions during today's session.	Hice preguntas de escala durante la sesión.
11	I asked coping questions related to the client's abilities that emerged during today's session.	Hice preguntas de afrontamiento relacionadas a las habilidades de los clientes que emergieron durante la sesión de hoy.
12	I asked questions to help the client think about how changes will affect the client's family and important others in their life.	Hice preguntas para ayudar al consultante a pensar acerca de cómo los cambios van a afectar a sus familiares y personas significativas en sus vidas.
13	I asked for feedback on the helpfulness of the session today from the client.	Pedí retroalimentación al consultante acerca de la utilidad de la sesión de hoy.

OFFICE OF RESEARCH SUPPORT

THE UNIVERSITY OF TEXAS AT AUSTIN

P.O. Box 7426, Austin, Texas 78713 · Mail Code A3200
(512) 471-8871 · FAX (512) 471-8873

FWA # 00002030

Date: 10/14/15

PI: Karla Gonzalez

Dept: Social Work, School of

Title: Cultural Adaptation of Solution Focused Brief Intervention for Individuals with Alcohol Use Disorders in Chile.

RE: Non-Human Subjects Research Determination

Dear Karla Gonzalez:

The Office of Research Support (ORS) reviewed the above protocol submission request and determined it did not meet the criteria for human subjects research as defined in the Common Rule (45 CFR 46) or FDA Regulations (21 CFR 56). IRB review and oversight is not required because the activities involve:

- ☐ No human interactions
- ☐ Classroom activities used to teach methodology and technique
- ☒ Program evaluation where results are not generalized to other services or programs
- ☐ Secondary use of de-identified data set (no direct or links to identifiers)
- ☐ Obtaining information that is not about living individuals
- ☐ Obtaining information from publicly available sets
- ☐ Biographical research that is not generalizable beyond the individual
- ☐ Archival research using existing literature
- ☐ Other (Explain):

At this time you are free to begin your research as IRB approval is not necessary. You should retain this letter with the respective research documents as evidence that IRB review and oversight is not required.

If you have any questions contact the ORS by phone at (512) 471-8871 or via e-mail at orsc@uts.cc.utexas.edu.

Sincerely,

James P. Wilson

James Wilson, Ph.D.
Institutional Review Board Chair

Appendix C: Training Syllabus

TRAINING SYLLABUS

UNIDAD ACADÉMICA
Escuela de Trabajo Social

NOMBRE DE LA ACTIVIDAD
Curso Intervención Breve Centrada en Soluciones (IBCS) para Trabajadores Sociales de la Atención Primaria.

VERSIÓN 2016

PRESENTACIÓN
Este curso entrega herramientas para implementar el modelo de intervención breve centrado en soluciones en la atención primaria.

FUNDAMENTACIÓN Y DESCRIPCIÓN GENERAL

La práctica diaria de los trabajadores sociales en la atención primaria requiere de habilidades de intervención directa, la cual se enmarca en contextos de intervenciones breves que requieren de alta capacidad de vinculación con los sujetos de intervención y su involucramiento en la generación de objetivos acotados y a corto plazo. Este curso es de alta relevancia en tanto ofrece una estrategia de intervención nueva en Chile para los trabajadores sociales y que puede ser de alta utilidad para realizar intervenciones con individuos, familias y grupos en el ámbito de la atención primaria. Los participantes conocerán las principales intervenciones y técnicas del modelo de intervención breve centrada en las soluciones (IBCS) y serán capaces de poner en práctica el modelo de intervención con altos niveles de fidelidad.

DIRIGIDO A / PÚBLICO OBJETIVO
Trabajadores sociales que trabajan en la atención primaria.

REQUISITOS DE INGRESO
- Título profesional universitario.
- Al menos un año de antigüedad trabajando en la atención primaria.

OBJETIVOS GENERALES

- Reconocer los aspectos teórico-prácticos del modelo de IBCS e incorporar los elementos generales y específicos de dicho modelo a sus prácticas diarias en la atención primaria.

OBJETIVOS ESPECÍFICOS Y CONTENIDOS

Módulo 1: Aspectos elementales de la IBCS
Horas cronológicas: 8 horas

Objetivos específicos:

- Revisar los fundamentos del modelo de IBCS.
- Reconocer las diferencias entre resolución de problemas y construcción de soluciones.
- Reconocer y aplicar elementos básicos del modelo de intervención breve centrada en las soluciones.

Contenidos:

- Historia y contexto del surgimiento del modelo de IBCS
- Resolver problemas vs. Construir soluciones
- Reglas de la IBCS
- Principales intervenciones
- Intervenciones específicas
- EARS
- Role playing

Módulo 2: Poniendo en práctica la IBCS
Horas cronológicas: 12 horas

Objetivos específicos:

- Aplicar las intervenciones principales y específicas definidas en el manual de IBCS.
- Desarrollar estrategias de alineamiento con el modelo de IBCS.

Contenidos:

- Revisión general de todos los contenidos
- Role playing
- Observación de videos
- Cómo mantenerse enfocado en las soluciones
- Check-lists y fidelidad con el modelo

Módulo 3: Supervisión y evaluación práctica la IBCS
Horas cronológicas: 10 horas

Objetivos específicos:

- Aplicar la IBCS en su ejercicio profesional bajo supervisión.

Contenidos:

- Aplicación de IBCS con casos reales

- Supervisión de la entrenadora en terreno
- Feedback y reflexión
- Consultoría y supervisión de casos

Evaluaciones:
- Módulo 1: Prueba de Contenidos 20%
- Módulo 2: Video Role Playing 40%
- Módulo 3: Evaluación de fidelidad a 3 sesiones bajo supervisión por espejo 40%

Bibliografía:
Beyebach, M. (2013). La Terapia Breve Centrada en las Soluciones.
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JEFE DE PROGRAMA

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EQUIPO DOCENTE

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MODALIDAD
Presencial.

METODOLOGÍA
- Clases expositivas.
- Estudio de casos.
- Supervisión directa de casos en terreno.
- Transferencia: puesta en práctica de los conocimientos adquiridos en una Unidad de Salud, bajo supervisión de la académica.

REQUISITOS DE APROBACIÓN

A) Asistencia: 85%.

B) Requisito académico: los alumnos deberán obtener una nota 4.0 o más y cumplir con el requisito de asistencia.

Los alumnos que aprueben las exigencias del programa recibirán un certificado de aprobación otorgado por la Pontificia Universidad Católica de Chile.

CALENDARIO CURSO INTERVENCION BREVE CENTRADA EN LAS SOLUCIONES PARA TRABAJADORES SOCIALES DE LA ATENCIÓN PRIMARIA

Modulo	Temas	fechas y horarios tentativos	Lugar
Modulo 1 8 horas	Historia y Contexto Problemas vs Soluciones Reglas de la IBCS Principales intervenciones Intervenciones Específicas EARS	viernes 8/1 de 9:00 a 13:00	ETSUC
		Viernes 15/1 de 9:00 a 13:00	ETSUC
Modulo 2 12 horas	Práctica de la IBCS paso a paso IBCS y trastornos del uso de alcohol Observación y análisis de videos Mantenerse en las soluciones Check lists	Viernes 22/1 de 9:00 a 13:00	ETSUC
		Viernes 29/1 de 9:00 a 13:00	ETSUC
	Práctica de la IBCS y uso de check lists e instrumentos de evaluación	Viernes 11/3 de 9 a 13:00	CESFAM JPII
Modulo 3 10 horas	Consultoria con Karla González en los dos CESFAMs en horarios acordado con los TS para supervisión directa y apoyo técnico	A convenir con cada TS	CESFAM JPII y La Bandera

APPENDIX D: TRANSLATED AND ADAPTED SFBT MANUAL FOR CHILEAN SOCIAL WORKERS.

MANUAL TERAPIA BREVE CENTRADA EN LAS SOLUCIONES PARA PERSONAS CON USO PROBLEMÁTICO DE ALCOHOL

INTRODUCCIÓN

Este documento ha sido construido para ofrecer una guía general y básica para la Terapia Breve Centrada en Soluciones (TBCS). Está basado en el manual original de Terapia Breve Centrada en Soluciones publicado por Bavelas y colaboradores (2013) bajo el alero de la Solution-Focused Brief Therapy Association (SFBTA) y disponible en Ingles en www.sfbta.org. La construccion del manual ha sido informada por un proceso de adaptación cultural realizado con población Chilena.

Este manual incluye los componentes enunciados en el manual original. Su contenido se organiza a partir de un primer capítulo llamado *Contextualización y Relevancia de la TBCS*, en el cual se revisará la información general de la TBCS, su descripción y justificación; la manera en la que TBCS contrasta con otros tratamientos; la compatibilidad de la TBCS con terapias complementarias; la población objetivo; y lo que se conoce acerca de la aplicación de la TBCS en poblaciones especiales. El segundo capítulo, llamado *Cómo Hacer TBCS*, incluye la descripción del formato de la TBCS; el formato de las sesiones y su contenido; la construcción de objetivos; los ingredientes activos específicos y comportamientos esperados en el profesional que implementa la TBCS y la naturaleza de la relación profesional-usuario en TBCS; las características y requisitos terapeuta; la formación del terapeuta; y la supervisión. Un tercer capítulo llamado *TBCS y Personas que Presentan Trastornos del Uso de Alcohol*, incluye una serie de recomendaciones para el trabajo con personas/familias con problemas de alcohol, para aquellos profesionales que implementen la TBCS con esta población en específico.

CAPÍTULO 1: CONTEXTUALIZACIÓN Y RELEVANCIA DE LA TBCS

La Terapia Breve Centrada en Soluciones (TBCS) surge a principios de los años 80 a partir del trabajo de Steve De Schazer e Insoo Kim Berg en el Centro de Terapia Familiar que ambos fundaron en Milwakee, Estados Unidos. Este es un modelo de intervención que a diferencia de otros modelos tradicionales de intervención social, hace un especial énfasis en los recursos y fortalezas de las personas y familias, se orienta hacia el futuro y sólo se enfoca en el pasado para relevar las experiencias exitosas (o excepciones) que las personas han tenido. El profesional se orienta a comprender lo que el consultante quiere que sea distinto en su vida.

Los principios de la TBCS son (Bavelas et al., 2013)

- Se basa en la construcción de soluciones en lugar de la resolución de problemas.
- El enfoque terapéutico debe ser el futuro deseado del cliente en lugar de los problemas del pasado o los conflictos actuales.
- Se anima a la persona/familia a aumentar la frecuencia de comportamientos útiles actuales.
- No hay problema que ocurra todo el tiempo. Hay excepciones, es decir, momentos en los que el problema pudo haber sucedido y no sucedió. Esta información puede ser utilizada por la persona/familia y el profesional para co-construir soluciones.
- Los profesionales ayudan a la persona/familia a encontrar alternativas a los patrones actuales no deseados relacionados con la conducta, la cognición y la interacción. Estas alternativas están dentro del repertorio de la persona/familia o bien pueden ser co-construidos en conjunto por los profesionales y las personas.
- A diferencia de las intervenciones de desarrollo de habilidades y la terapia de comportamiento, el modelo asume que ya existen comportamientos que son soluciones para la persona/familia.
- Se afirma que los pequeños incrementos de cambio conllevan a grandes incrementos de cambio.
- Las soluciones de la persona/familia no están necesariamente relacionadas directamente con los problemas identificados por ellos mismos o el profesional.
- Las habilidades de conversación que el profesional requiere para invitar a la persona/familia a construir soluciones son diferentes a las habilidades necesarias para diagnosticar y tratar los problemas.

Evidencia de la Terapia Breve Centrada en Soluciones

Revisiones sistemáticas y meta-análisis de la TBCS han demostrado que este modelo tiene pequeños a medianos efectos en el tratamiento de distintas condiciones psicosociales en niños y adultos (Gingerich & Peterson, 2013; Kim, 2008; Stams, Dekovic, Buist, y De Vries, 2006), siendo un enfoque especialmente eficaz en adultos con depresión (Bavelas et al, 2013). No obstante, la TBCS ha sido reconocida como una práctica basada en la evidencia (PBE) en los Estados Unidos y aparece en el Registro Nacional de Administración de Servicios de Salud Mental de los Programas y Prácticas de Abuso de Sustancias (http://www.nrepp.samhsa.gov) y en la Guía de Programas de Prevención Modelo de la Oficina de Justicia Juvenil y Delincuencia Basada en la Evidencia (http://www.ojjdp.gov/mpg/). También existe un creciente desarrollo de estudios con diseños experimentales más rigurosos que demuestran la eficacia de TBCS (Franklin, Trepper, Gingerich, y McCollum, 2012).

La TBCS es un modelo de intervención breve que se ha comenzado a aplicar en Latinoamérica y particularmente en Chile muy recientemente (ver por ejemplo, Cordero, Cordero, Natera, Caraveo, 2009; Schade, Torres & Beyebach, 2011). Una revisión sistemática (González, Franklin & Kim, en prensa) reporta que en los pocos estudios experimentales realizados en América Latina, los resultados tienden a ser positivos, especialmente en salud mental y adultos mayores, sin embargo se necesitan más estudios aplicados para obtener conclusiones acera de su eficacia en nuestro continente con diversas temáticas y poblaciones.

Base teórica de la TBCS

La TBCS se sustenta principalmente en dos enfoques epistemológicos, la teoría de sistemas y el construccionismo social. Sin embargo, su origen es a partir de la práctica de la terapia familiar cuyas bases teóricas provenían del constructivismo social y la comunicación colaborativa (Watzlawick, Beavin-Bavelas & Jackson, 2011). Dentro de la teoría de sistemas, la cibernética de segundo orden, hace un giro y amplía la mirada que los terapeutas tenían de la familia, planteando que el cambio ocurre cuando los patrones y la estructura del sistema familiar cambian (Becvar & Becvar, 1982). Asimismo, comienza a situar al terapeuta dentro del sistema familiar, estableciendo una relación familia-profesional más horizontal, lo cual sugiere una visión de las familias menos patologizadora y disfuncional (Hoffman, 1981). Otro elemento de la teoría de sistemas es el clásico modelo ecológico de Bronfenbrenner (1979), el cual es también relevante para la TBCS, pues la noción de que los individuos se encuentran en constante interacción con otros sistemas además de sus familias y a su vez son influidos por estos, provee un marco conceptual para comprender la relación entre la persona/familia y el profesional y entre la persona/familia y su contexto (Lipchick, 2002; Pichot & Smock, 2009).

El enfoque de la co-construcción de la realidad emerge desde varias disciplinas, incluyendo aportes desde la sociología, la psicología y la comunicación

(por ejemplo, Berger & Luckmann, 1966; de Shazer, 1994; Gergen, 2009; McNamee & Gergen, 1992). El uso del lenguaje y el proceso de co-construcción son parte integral del proceso de cambio de la TBCS. Los detalles empíricos del enfoque de la TBCS hacia el uso del lenguaje en la conversación tienen una base experimental sólida en la investigación contemporánea psicolingüística (Bavelas, 2012). Por último, se han desarrollado estudios sobre los procesos dialógicos específicos en los cuales ocurre la co-construcción, tanto en TBCS como en el contraste con otras terapias (por ejemplo, Phillips 1998, 1999; McGee 1999; McGee, Del Vento, y Bavelas, 2005; Tomori, 2004; Tomori y Bavelas, 2007; Korman, Bavelas, y De Jong, 2013; Smock Jordan, Froerer, y Bavelas, 2013; Froerer & Smock Jordan, 2013). Además, existen otras investigaciones acerca de los procesos de cambio que muestran que las técnicas terapéuticas utilizadas en TBCS pueden tener efectos positivos sobre el cambio de las personas. Por ejemplo, los procesos terapéuticos, tales como preguntas pre-suposicionales, "*hablar de soluciones*", "promover la esperanza" y expectativas positivas en las personas respecto del cambio aumentaron los resultados positivos en sus objetivos (Bavelas et al., 2013). Técnicas como la pregunta de escala y la pregunta del milagro también han mostrado lograr sus fines previstos en las sesiones de terapia (McKeel, 2012).

Proceso terapéutico centrado en las soluciones

> Proceso psicoterapéutico se define como:
> *Todo lo que ocurre entre el usuario y psicoterapeuta durante la psicoterapia. Esto incluye las experiencias, actitudes, emociones y comportamientos del usuario y el terapeuta, así como la dinámica o la interacción entre ellos (Vandebos, 2007).*

La manera en que la TBCS comprende el proceso terapéutico es única en al menos tres aspectos. En primer lugar, otros modelos se enfocan principalmente en lo que sucede dentro del cliente. Por ejemplo, en la definición de "mecanismos de cambio" en la psicoterapia, Nock (2007, p. 85) incluye sólo los procesos psicológicos o biológicos y excluye explícitamente la comunicación entre el profesional y la persona. La TBCS iguala el proceso terapéutico al diálogo terapéutico, es decir, el diálogo terapéutico *es* lo que sucede entre el profesional y la persona que consulta (por ejemplo, McKergow y Korman, 2009). El proceso de cambio en TBCS es la co-construcción entre el profesional y la persona/familia de lo que es importante para ella: sus metas, éxitos relacionados y recursos. La formación y la práctica en TBCS se centra en los detalles de cómo se produce este proceso conversacional, poniendo atención a las interacciones entre el profesional y persona/familia momento a momento (por ejemplo, De Jong y Berg, 2013; de Shazer et al., 2007).

En segundo lugar, el enfoque de la TBCS hacia el diálogo como proceso terapéutico esencial se centra en lo que es *observable* en la comunicación, y las interacciones sociales entre cliente y terapeuta. Como se ilustra a continuación, los intercambios específicos a través de los cuales ocurre el proceso, conocido como co-

construcción, son observables, mientras que las inferencias o caracterizaciones de comunicación terapéutica o relaciones globales no lo son. Así, el proceso de TBCS consiste en lo que *dice y hace* el terapeuta más que en sus intenciones (Bavelas et al., 2013). Este compromiso con la observación sistemática como la base de lo que es y no es útil en TBCS se remonta a sus orígenes en el Centro de Terapia Familiar Breve (CTBF) en Milwaukee, fundada por de Shazer, Berg, y colegas. La primera investigación en el CTFB fue exploratoria y cualitativa, involucrando una intensa observación de sesiones de terapia a través de un espejo unidireccional por un equipo de profesionales con experiencia, profesores clínicos, y estudiantes de posgrado, así como la posterior revisión de video-grabaciones. Los investigadores querían observar *cuando* las personas/familias hacían progresos (de acuerdo a lo que ellas definían como progreso) y examinaron lo que podrían estar haciendo los profesionales que estaba contribuyendo a aquel progreso (Bavelas et al., 2013). A través de discusiones abiertas durante varios años, el equipo inventó y experimentó con varias técnicas nuevas que con el tiempo se convirtieron en piezas fundamentales de SFBT, incluyendo preguntas sobre el cambio antes de la sesión, las excepciones, la pregunta del milagro, así como las tareas de fórmula (de Shazer 1985, p. 119-136). Así como cada técnica se convirtió en parte de la práctica de la TBCS, mayor observación e investigación de los procesos respaldaron su utilidad. Esta forma de observar, inventar algo nuevo, y recolectar datos para probar la utilidad de las prácticas específicas es descrita por varios autores (Adams, Piercy, y Jurich, 1991; De Jong y Berg, 2013; Lipchik, Derks, Lacourt, y Nunnally, 2012; Weiner-Davis, de Shazer, y Gingerich, 1987, Miller, 2004).

En tercer lugar, la TBCS se desarrolló utilizando una base empírica sobre el uso del lenguaje en el diálogo, la cual tiene un fundamento experimental sólido en la investigación psicolingüística contemporánea (por ejemplo, revisión en Bavelas, 2012). Por lo tanto, la evidencia de la TBCS comenzó sobre cimientos firmes en investigación básica y los desarrollos teóricos fueron aplicados más tarde en la clínica de terapia familiar, donde estos procesos de comunicación se perfeccionaron aún más en la práctica de la psicoterapia breve (Bavelas et al., 2013).

El proceso de la TBCS como "escuchar, seleccionar, construir"

En la TBCS, terapeutas y clientes participan en un proceso de co-construcción que conlleva a que los usuarios hablen acerca de sí mismos y de sus situaciones de maneras nuevas y distintas. La co-construcción es un proceso de comunicación colaborativa en donde hablante y oyente colaboran en la producción de información, y esta información, a su vez, sirve para cambiar los significados y las interacciones sociales. Los principios de este proceso de conversación entre el terapeuta y el usuario son los mismos, independientemente del motivo de consulta que cada cliente trae a la terapia. La conversación siempre se centra en lo que los clientes quieren que sea diferente en su presente y futuro, y cómo hacer para que ello suceda. La TBCS no es un enfoque que tiene una larga fase de evaluación cuya

intención es diagnosticar clientes. Por el contrario, desde el comienzo los profesionales utilizan un lenguaje de cambio que facilita la fijación de objetivos y soluciones centradas en las personas. En las entrevistas centradas en soluciones, las preguntas del modelo y las respuestas de los profesionales tienen la intención de iniciar un proceso co-constructivo que De Jong y Berg (2013), inspirados por Steve de Shazer (1991; 1994; De Shazer et al, 2007), llamaron *escuchar, seleccionar y construir*.

En este proceso, el profesional centrado en soluciones escucha y selecciona las palabras y frases del lenguaje de la persona/familia que son indicadores (inicialmente, a menudo sólo pequeñas expresiones) de algún aspecto de una solución, tales como la articulación de lo que es importante para la persona/familia, lo ella pudiera querer, éxitos relacionados (por ejemplo, excepciones), o las habilidades y recursos de la persona/familia. Una vez que ha hecho la selección, el profesional compone una pregunta próxima (por ejemplo, escala o afrontamiento) u otra respuesta (por ejemplo, parafraseo o resumen) que se conecta con el lenguaje utilizado por la persona/familia y le invita a continuar construyendo una versión más clara y detallada de algún aspecto de una solución. En la medida que la persona/familia responde desde su propio marco de referencia, el terapeuta sigue *escuchando, seleccionando y componiendo* la siguiente pregunta o respuesta centrada en soluciones, la cual se basa en lo que el cliente ha dicho. Es a través de este proceso continuo de escucha, selección, y construcción sobre el lenguaje del cliente que los profesionales y personas/familias que consultan, co-construyen en conjunto nuevos significados y nuevas posibilidades de soluciones. Los profesionales centrados en las soluciones se esfuerzan para evitar hacer suposiciones acerca de supuestos "significados reales o subyacentes" de lo que las personas/familias están diciendo. En lugar de leer entre líneas, los profesionales se auto-disciplinan para escuchar y trabajar dentro del lenguaje de la persona/familia, por permanecer cerca ellos y por usar las palabras que ellos utilizan.

La práctica de escuchar, seleccionar y construir se ilustra en el siguiente diálogo entre un terapeuta centrado en soluciones (Harry Korman) y una joven madre que pasaba por un divorcio difícil y comenzaba una nueva vida con su hijo de 19 meses (De Jong, Bavelas, y Korman, en prensa). Este extracto se produjo a principios de la sesión (justo después de la introducción) y comenzó la co-construcción de lo que la mujer podría querer al reunirse con el terapeuta.

1	***Korman***	Entonces, está bien si empezamos con ¿qué tendrá que suceder como resultado de que haya venido aquí hoy - esta tarde, mañana, pasado mañana - para sentir que ha sido algo útil el estar aquí?
2	***Mujer***	Mmm
3	***Korman***	[se mantiene en silencio y se acomoda en una postura de escucha, una mano afirmando su mentón, mirando directamente a la consultante]

4	***Mujer***	No creo que sea… [ríe, luego hace un gesto al terapeuta con un leve encogimiento de hombros]
5	***Korman***	[asiente] es una pregunta difícil [gesticula y luego retorna a una postura de escucha]
6	***Mujer***	[hablando sobre lo que dice el terapeuta] siquiera mirar tan lejos…
7	***Korman***	Se mantiene en postura de escucha, se mantiene en silencio]
8	***Mujer***	No sé, supongo que tal vez para ordenar todo lo que estoy…
9	***Korman***	[inclina su cabeza hacia la derecha como mostrando mayor interés, luego, posiciona su lápiz para escribir]
10	***Mujer***	Estoy sintiendo. No sé exactamente lo que es todavía.
11	***Korman***	[asintiendo lentamente, mira abajo y escribe brevemente y luego mira a la usuaria de nuevo manteniendo el lápiz en el cuaderno]
12	***Mujer***	No sé [gestos con la mano izquierda hacia el terapeuta]
13	***Korman***	[asiente]
14	***Mujer***	No sé exactamente lo que me preocupa. Como… o sea yo…
15	***Korman***	[asiente continuamente]
16	***Mujer***	Estoy en el proceso de atravesar por un divorcio, entonces
17	***Korman***	[mira el cuaderno y escribe brevemente, cuando la usuaria termina de hablar hace un gran gesto de asentimiento]
18	***Mujer***	Estoy segura de que eso es… [Hace un gesto hacia el terapeuta con las dos manos y luego las pone en sus piernas]… la mayor parte.
19	***Korman***	Mmmm [asintiendo]
20	***Mujer***	Recientemente no he podido dormir muy bien.
21	***Korman***	[asiente]
22	***Mujer***	Así que pensé que tal vez esto podría [pausa] ayudarme a resolver lo que sea que necesite para
23	***Korman***	[Asiente y dice:] bien
24	***Mujer***	Rehacer mi vida.
25	***Korman***	[mirando hacia abajo y escribiendo mientras habla:] Ayudarle a ordenar algo para rehacer su vida. [Luego asiente y la mira, pausa, luego pregunta con gestos hacia ella:] entonces ¿Cuál sería un sentimiento, un pensamiento, una acción - algo que puedes hacer, o pensar o sentir - que te diría que estarías rehaciendo tu vida? [mantiene su vista hacia ella]
26	***Mujer***	*Mmm [pausa]*
27	***Korman***	¿Esta tarde, mañana? [luego mira hacia abajo y pone su lápiz como para empezar a escribir; mira hacia arriba y mueve su cabeza cuando ella empieza a hablar]
28	***Mujer***	Supongo que … simplemente relajarse tal vez…

29	***Korman***	[con un gran gesto de asentimiento, mirando abajo y escribiendo] Relajarse.

El terapeuta empezó en el # 1 con una pregunta acerca de lo que la mujer consultante podría querer por "venir hoy aquí." En lugar de responder inmediatamente, la mujer respondió en el # 2 con "Um." Este tipo de pausa y de respuesta mínima por ella para la pregunta planteada en el # 1 es común en las entrevistas de TBCS (debido a las preguntas inusuales), al igual que la respuesta del terapeuta TBCS en el # 3. En lugar de decir algo, el terapeuta se acomodó en una postura de escucha y miró directamente a la consultante, esperando a que ella dijera algo más sobre algún aspecto de una solución (por ejemplo, lo que ella quiere, sus recursos o competencias). En este punto, el terapeuta estaba atento a la espera de una construcción inicial de lo que la mujer podría esperar de la reunión con un profesional. En el # 4, ella nuevamente no ofreció una respuesta directa, en vez de eso dijo, con un encogimiento de hombros, "No creo que sea…." En el # 5, el terapeuta reconoció que él había hecho una "pregunta difícil" y volvió a su postura de escucha. En el # 6, la consultante se superpone y terminó su respuesta con "--siquiera mirar tan lejos." Esta respuesta, que se refiere al futuro, mostró que había entendido la pregunta inicial acerca de lo que le gustaría ver que suceda en el futuro, por lo que una vez más el terapeuta se puso a esperar más respuesta. En los # 8, # 10, # 12, # 14, # 16, # 18, # 20 y # 22 la usuaria ofreció poco a poco una construcción de lo que puede ser que ella desee obtener de esta reunión. Mientras ella hacía esto, el terapeuta habla poco pero su interés y la comprensión de las palabras de la usuaria aparece regularmente a través de comportamientos comunicativos tales como inclinar la cabeza hacia un lado, poniendo su lápiz como si fuera a escribir, mirando hacia abajo y escribiendo brevemente, mirándola a ella, y asintiendo con la cabeza. En los # 19 y # 23, ofreció expresiones verbales mínimas como "Mm, mm" y "bien".

No fue hasta el # 25 que el terapeuta dijo algo más allá de una respuesta verbal mínima. Sus palabras en este punto son un claro ejemplo de la selección y construcción que define la TBCS. Primero, selecciona "ayudarle a ordenar algo para rehacer su vida." Al seleccionar estas palabras de en medio de todo lo que la consultante había dicho, el terapeuta da a entender que estas palabras en particular eran la parte importante de la respuesta a su pregunta original en el # 1. Su selección también significó que él optó por ignorar que ella "no estaba mirando tan lejos," que ella "no sabe lo que le está preocupando," que estaba "pasando por un divorcio," que estaba segura de que el divorcio era "la mayor parte", y que "recientemente no [ha] podido dormir muy bien."

En el # 25, el terapeuta comenzó el proceso de construcción mediante la incorporación de la construcción inicial del cliente de lo que quería ("para rehacer mi vida") en su siguiente pregunta, "¿Y cuál sería un sentimiento, un pensamiento, una acción, algo que puedes hacer o pensar o sentir que te diría que estarías

rehaciendo tu vida, esta tarde o mañana?" Su elección de palabras no sólo se vinculaba estrechamente con lo que ella había dicho en el # 22 y # 24, pues esta elección también ayudó a avanzar en una nueva dirección. Al pedir detalles más concretos que le indicarían a ella que estaba "Rehaciendo su vida", en el # 28, la consultante respondió con un detalle: "Supongo que como-simplemente, relajarse tal vez." En # 29, el terapeuta volvió a hacer una típica selección centrada en soluciones, repitiendo solamente "relajarse", haciendo hincapié en un indicador posiblemente importante de "rehacer su vida." Él decidió ignorar otras palabras ("supongo", "tal vez") que indica una falta de certeza. Luego de la última respuesta de la consultante, el terapeuta podría seguir construyendo con otra pregunta que conecte con "relajarse".

Ingredientes generales de la Intervención centrada en soluciones

La mayoría de las psicoterapias, incluida la TBCS, consiste en conversaciones. En la TBCS hay tres ingredientes principales que se relacionan con estas conversaciones:

En primer lugar, hay temas generales. Las conversaciones de la TBCS se centran en las preocupaciones de la persona/familia; quién y qué es importante para ella; una visión de un futuro deseado; sus excepciones, fortalezas y recursos relacionados con esa visión; la ampliación de su nivel de motivación y confianza en la búsqueda de soluciones; y la ampliación continua de sus progresos hacia el logro de un futuro preferido.

En segundo lugar, como se indica en el apartado anterior, las conversaciones centradas en las soluciones implican un proceso terapéutico de co-construcción de significados alterados o nuevos en la persona/familia. Este proceso se pone en marcha en gran medida por los terapeutas al hacer preguntas centradas en las soluciones acerca de los temas de conversación identificados en el párrafo anterior. Estas soluciones se conectan con y se construyen a partir de los significados expresados por la persona/familia.

En tercer lugar, los terapeutas utilizan una serie de técnicas específicas de preguntas y respuestas que invitan a la persona/familia a co-construir una visión de un futuro deseado y a aprovechar sus éxitos pasados, fortalezas y recursos para hacer realidad dicha visión.

Establecimiento de objetivos y terapia subsecuente

La definición de *metas específicas, concretas y realistas* es un componente importante de la TBCS. Los objetivos se formulan y amplían a través de la conversación centrada en las soluciones acerca de lo que las personas o familias quieren que sea diferente en el futuro. En consecuencia, en TBCS, ellos establecen los objetivos. Objetivos útiles en TBCS son: (1) relevantes y personalmente significativos, (2) plantean positivamente lo que las personas/familias van a hacer

en lugar de lo que ellos no van a hacer, (3) se establecen en términos de comportamiento y como el primer pequeño paso, (4) se encuentran dentro del control de la persona, (5) son algo nuevo y diferente, y (6) se plantean como un comportamiento que puede practicar regularmente (Lee, Sebold, y Uken, 2003; Lee, Uken, y Sebold, 2007). Una vez que una nueva formulación se plantea, la conversación se centra en las excepciones relacionadas con los objetivos, ampliando regularmente cómo la persona/familia se acerca a sus metas o a una solución, y co-construyendo los próximos pasos que les ayudarán a llegar a sus futuros preferidos.

Cómo la TBCS contrasta con otros tratamientos

La TBCS es muy similar a los modelos basados en competencias de resiliencia, como algunos de los componentes de la entrevista motivacional (Miller & Rollnick, 2002; Miller, Zweben, DiClemente, y Rychtarik, 1994), la perspectiva de las fuerzas y la psicología positiva. También hay algunas similitudes entre la TBCS y la terapia cognitivo-conductual, aunque en este último modelo el profesional asigna los cambios y las tareas, mientras que los profesionales centrados en la solución animan a las personas/familias a hacer más de su propio comportamiento de excepción anterior y/o probar comportamientos que son parte de la descripción de su objetivo. El foco de la TBCS en el comportamiento, la descripción y el contexto social es similar a la tercera “ola” de las terapias conductuales. Sin embargo la TBCS no se basa exclusivamente en las mismas teorías ni en las mismas técnicas empleadas en sus procesos de cambio. La TBCS también tiene algunas similitudes con la Terapia Narrativa (por ejemplo, Freedman y Combs, 1996) en que ambas adoptan una postura no-patológica, son centradas en la persona, y trabajan para crear nuevas realidades, como parte del enfoque. La TBCS es muy distinta en términos de la filosofía subyacente y supuestos a cualquier enfoque que requiere de "elaboración" del problema o de un foco intensivo en éste para resolverlo, o cualquier enfoque que se centre principalmente en el pasado y no el presente o futuro.

Otra característica que distingue la TBCS de otros modelos de tratamiento es su opinión sobre la evaluación. Al contrario de los modelos de tratamiento que ven a los profesionales como poseedores de conocimiento experto de diagnóstico y a los clientes como los objetos de evaluación, la evaluación centrada en soluciones destaca a la persona que consulta como el "evaluador" que constantemente se auto-evalúa respecto de lo que quiere; respecto de sus posible soluciones al problema, con el fin de acercarse al futuro deseado; respecto de los objetivos del tratamiento; respecto de sus fortalezas y recursos que puede utilizar para llegar al futuro deseado; respecto de lo que pudiera ser una ayuda en su proceso de cambio; respecto de qué tan comprometido o motivado está para hacer realidad su cambio; y respecto de la rapidez con la que ellos quieren proceder con el cambio; etc. (Lee et al., 2003; Lee, 2013). Al mismo tiempo, los profesionales centrados en las soluciones son expertos en "conversar sobre el cambio" pues sostienen conversacioes que van

en busca de descripciones de una realidad alternativa y beneficiosa (de Shazer, 1994).

Qué es diferente acerca del proceso terapéutico en la TBCS

En la sección de proceso terapéutico se mencionan tres características únicas del enfoque TBCS para el proceso terapéutico: Se define el proceso terapéutico (y el mecanismo de cambio) como el diálogo entre el terapeuta y el cliente. Se centra en lo que es observable en este diálogo en lugar de inferencias sobre lo que hay detrás de él. Y se basa en la evidencia de investigación de disciplinas que estudian los procesos del lenguaje. Como resultado, los profesionales centrados en las soluciones se focalizan intensamente en cómo utilizar el lenguaje durante la terapia. En la TBCS los profesionales escuchan atentamente el lenguaje de sus consultantes, lo que es importante para ellos, lo que ellos podrían querer, la evidencia de sus competencias y los éxitos relacionados con lo que quieren, y los recursos propios y externos de los consultantes. **El objetivo es construir una versión cada vez más detallada de lo que los las personas/familias quieren que sea diferente, así como la manera en que usando sus recursos disponibles (propios y del contexto) pueden lograr de esa versión de lo que quieren que suceda.**

Compatibilidad con terapias complementarias

Las preguntas e intervenciones de la TBCS pueden ser fácilmente utilizadas como complemento de otras terapias. Uno de los principios originales y centrales de la TBCS- "Si algo funciona bien, haga más de lo mismo" –sugiere que los terapeutas deben animar a sus clientes a continuar con otras terapias y enfoques que les son útiles. Por ejemplo, se anima a los usuarios a (a) seguir tomando la medicación prescrita, (b) permanecer en grupos de autoayuda si les está ayudando a lograr sus metas, o (c) iniciar o continuar la terapia familiar. Por último, es un error pensar que la TBCS es filosóficamente opuesta a los tratamientos tradicionales de abuso de sustancias. Por el contrario, si una persona está en tratamiento tradicional o lo ha tenido en el pasado y el tratamiento ha ayudado, se le debe animar a seguir haciendo lo que está resultando positivo en su vida. Como tal, la TBCS podría utilizarse como un componente de un programa de tratamiento integral o bien, como un complemento.

Poblaciones objetivo

Se ha comprobado que la TBCS es clínicamente útil en programas de tratamiento para adolescentes y adultos ambulatorios en los EE.UU. (Pichot y Dolan, 2003), y como un complemento al tratamiento de pacientes hospitalizados más intensivos en Europa. La TBCS está siendo utilizada para tratar toda la gama de trastornos de salud mental, y también se está utilizando en ámbitos de la educación

y de negocios. Meta-análisis y revisiones sistemáticas de estudios experimentales y cuasi-experimentales indican que la TBCS es una intervención promisoria para jóvenes y adultos con trastornos del ánimo y problemas de conducta. La TBCS también se ha utilizado a menudo con problemas escolares y académicos, mostrando tamaños de efecto que van de mediano a grande (muy buenos en ciencias sociales; Gingerich y Peterson, 2013; Kim, 2013; Kim y Franklin, 2008). Si bien, en Latinoamérica, la aplicación, y por ende, la investigación es aún incipiente, los estudios aplicados muestran tendencias positivas en términos de los efectos que la TBCS tiene en adultos y adultos mayores. Además de ello, se han realizado estudios con niños y jóvenes Latinos en escuelas de Estados Unidos, los cuales también muestran tendencias positivas (Gonzalez et al., 2016).

Satisfacer las necesidades de las poblaciones especiales

Mientras la TBCS puede ser útil como tratamiento primario para muchos individuos en el sector ambulatorio, es muy probable que personas con problemas psiquiátricos severos, problemas biomédicos o situaciones de vida inestable necesiten servicios médicos, psicológicos y sociales adicionales. En esas situaciones, la TBCS puede ser parte de un programa de tratamiento más integral. Análisis de moderación en un meta-análisis llevado a cabo por Stams y equipo (2006) encontró que la TBCS tenía un efecto estadísticamente significativo al comparar los resultados con personas que no recibieron tratamiento ($d = 0,57$, $p < 0,01$), aunque este efecto no era mayor al que obtuvieron personas que recibieron el tratamiento habitual. Las personas que residen en instituciones, incluidos delincuentes y los pacientes con esquizofrenia, se beneficiaron más de la TBCS ($d = 0,60$) que las personas que no se encuentran en residencias, como familia/pareja ($d = 0,40$) y estudiantes ($d = 0,21$). Dos revisiones de estudios empíricos sugieren que la TBCS es efectiva con trastornos del ánimo como la depresión (Kim, 2008; Gingerich, 2013).

La TBCS se utiliza en contextos clínicos y no clínicos alrededor de todo el mundo. Sin embargo, la investigación en torno a la eficacia de TBCS con poblaciones de minorías étnicas es limitada, especialmente en los Estados Unidos. Aunque vale la pena señalar que a la fecha existe un cúmulo importante de investigaciones internacionales en Europa, China continental, Taiwán, Hong Kong y Japón (Franklin & Montgomery, 2013) que examinan la efectividad de la TBCS en dichas poblaciones. Además, Kim (2013) editó un libro de práctica clínica sobre la aplicación de la terapia breve centrada en soluciones con los consultantes de minorías y Corcoran (2000) ha escrito un marco conceptual para ayudar a entender cómo la TBCS puede ser efectiva con grupos minoritarios. Franklin y Montgomery (2013) proporcionan un desglose de las características demográficas raciales de los diversos estudios aplicados revisados. Los resultados muestran que la mayoría de las personas que recibieron TBCS fueron caucásicos (71,7%), seguidos de afroamericanos (12,3%) y latinos (12,3%). Cabe señalar que estas cifras son

similares a las proporciones de población estadounidense lo cual se condice con que la mayoría de los estudios revisados se realizaron en los EE.UU.

CAPÍTULO 2: CÓMO HACER TBCS

Ingredientes activos específicos

Algunos de los principales ingredientes activos en la TBCS son: (a) el desarrollo de una alianza terapéutica de cooperación con la persona/familia; (b) la construcción de una solución versus el foco en un problema; (c) el establecimiento de metas alcanzables medibles; (d) el centrarse en el futuro a través de preguntas y discusiones orientadas hacia el futuro; (e) el monitoreo constante de los objetivos para facilitar que la persona/familia evalúe sus progresos alcanzados; y (f) centrarse en la conversación sobre las excepciones a los problemas, especialmente aquellas excepciones relacionadas con lo que la persona/familia quiere que sea distinto, y a su vez, alentándolos a hacer más de lo que hicieron para hacer que las excepciones ocurran.

Naturaleza de la relación consultante-terapeuta

Con la TBCS, el profesional es visto como un colaborador y consultor, que ayuda a las personas o familias a alcanzar sus metas. En este modelo, las personas o familias consultantes hablan más que el terapeuta, y lo que hablan es considerado la piedra angular de la resolución de sus quejas. Por lo general, los profesionales centrados en las soluciones usarán métodos más indirectos, tales como un extenso interrogatorio acerca de las soluciones y excepciones anteriores. En la TBCS, el consultante es el experto, y el profesional toma una postura de "no saber" y de "liderar desde atrás" a través de preguntas y respuestas centradas en soluciones.

Estructura y formato de la sesión

Las principales intervenciones se toman desde de Shazer, et al. (2007).

UNA ACTITUD COLABORADORA, POSITIVA Y CENTRADA EN SOLUCIONES

Uno de los aspectos más importantes de la TBCS es el tono y la postura general tomada por el terapeuta. La actitud general es positiva, respetuosa y llena de esperanza. Hay una creencia general de que las personas son muy resilientes y esto se utiliza continuamente para hacer cambios. Además, hay una fuerte creencia de que la mayoría de la gente tiene la fuerza, la sabiduría y la experiencia para efectuar el cambio. Lo que otros modelos ven como "resistencia" por lo general se ve como: (a) mecanismos de protección natural o el deseo realista de la gente de ser cautelosa e ir poco a poco; (b) un error del profesional, es decir, una intervención que no se ajusta a la situación de los clientes. Todos estos factores hacen que las sesiones tiendan a sentirse como espacios de colaboración en lugar de jerárquicas (aunque como se señaló anteriormente, los terapeutas SFBT "lideran desde atrás"), y de cooperación en vez de confrontación.

BUSCANDO SOLUCIONES ANTERIORES

Profesionales centrados en la solución han aprendido que la mayoría de la gente ha resuelto previamente muchos, muchos problemas. Esto puede haber sido en otro tiempo, otro lugar, o en otra situación. El problema también puede haber vuelto. La clave es que la persona ha resuelto su problema, aunque sea por un corto tiempo.

BUSCANDO EXCEPCIONES

Incluso cuando una persona o familia no tiene una solución anterior que se pudiera repetir, la mayoría tiene ejemplos recientes de excepciones a su problema. Una excepción es considerada como un momento en que un problema pudo haber ocurrido, pero no ocurrió. La diferencia entre una solución anterior y una excepción es pequeña, pero significativa. Una solución anterior es algo que la familia ha intentado por su cuenta, que se ha trabajado, pero por alguna razón no han seguido esta solución exitosa, y probablemente se ha olvidado. Una excepción es algo que sucede en lugar del problema, con o sin la intención del cliente o tal vez incluso con o sin su comprensión.

PREGUNTAS VERSUS DIRECTRICES O INTERPRETACIONES

Las preguntas son un elemento importante de comunicación de todos los modelos de terapia. Los terapeutas utilizan preguntas a menudo con todos los enfoques, mientras toman una historia, cuando hacen el ingreso al comienzo de una sesión, o cuando averiguan cómo le fue a la familia con una tarea. Los profesionales centrados en las soluciones, sin embargo, hacen de las "preguntas" la herramienta de comunicación e intervención primaria. Asimismo, tienden a no hacer interpretaciones, y muy raramente desafían o confrontan a un consultante.

PREGUNTAS CENTRADAS EN EL PRESENTE Y FUTURO VERSUS ENFOQUE ORIENTADO AL PASADO

Las preguntas que los profesionales centrados en las soluciones hacen casi siempre se centran en el presente o en el futuro, y la atención se centra casi exclusivamente en lo que la persona/familia quiere que ocurra en su vida o en elementos de esto que ya estén sucediendo. Cuando se pregunta sobre el pasado, por lo general es acerca de cómo la persona/familia se sobrepuso a una dificultad similar o cuáles son las fortalezas o recursos del pasado que se pueden usar para el logro del futuro preferido. Esto refleja la creencia básica de que los problemas se resuelven mejor al centrarse en lo que ya está funcionando y en cómo a las personas les gustaría que sus vidas sean, en lugar de centrarse en el pasado por su propio bien y el origen de los problemas.

ELOGIOS O FELICITACIONES

Los elogios son otra parte esencial de la TBCS. La validación de lo que las personas/familias ya están haciendo bien y el reconocer lo difícil que son sus problemas anima a las personas/familias a cambiar y transmite el mensaje de que el profesional ha estado escuchando (es decir, entiende) y se preocupa por ellos (Berg & Dolan, 2001). Los elogios en las sesiones de terapia pueden ayudar a acentuar lo que las personas están haciendo y que está funcionando bien.

"EMPUJONCITO" SUAVE PARA HACER MÁS DE LO QUE ESTÁ FUNCIONANDO

Una vez que los profesionales centrados en las soluciones han creado un marco positivo a través de elogios y luego que han descubierto algunas previas soluciones y/o excepciones al problema, dan un pequeño "empujoncito" a la persona o familia que consulta para hacer más de lo que ha funcionado bien anteriormente, o para intentar los cambios que han enunciado en la sesión y que les gustaría probar, con frecuencia llamado "un experimento". Es raro que un profesional centrado en las soluciones dé una sugerencia o tarea que no se basa en las soluciones o excepciones anteriores de las personas que asiste. Siempre es mejor si las ideas de cambio y tareas emergen desde la persona/familia, al menos indirectamente, durante la conversación, en lugar de emerger desde el profesional debido a que dichos comportamientos son familiares para ellos.

Intervenciones específicas:

EL CAMBIO PRE-SESIÓN

Al principio o cerca del principio de la primera sesión de terapia, los terapeutas TBCS pueden preguntar: "¿Qué cambios nota usted que han ocurrido o comenzado a suceder desde que tomo la hora para esta sesión?"

Esta pregunta tiene tres respuestas posibles. En primer lugar, pueden decir que no ha pasado nada. En este caso, el terapeuta simplemente sigue y comienza la sesión preguntando algo así como: "¿Cómo puedo ser útil para usted hoy?", o "¿Qué tendría que pasar en esta sesión para que usted sienta que sirvió?", o "¿Cómo sabría su mejor amigo si esta sesión le sirvió? ", o" ¿Qué tendría que ser diferente en su vida después de esta sesión para que usted sienta que fue una buena idea venir a hablar conmigo?"

La segunda respuesta posible es que las cosas han comenzado a cambiar o mejorar. En este caso, el profesional hace muchas preguntas acerca de los cambios que han comenzado a ocurrir, pidiendo muchos detalles. Esto inicia el proceso de "conversación sobre soluciones", haciendo hincapié en las fortalezas y resiliencias del cliente desde el principio, y permite preguntar: "¿Entonces, le gustaría que los cambios continuaran en esta dirección?" ofreciendo así el comienzo de un objetivo concreto y positivo.

La tercera respuesta posible es que las cosas están casi iguales. Y el terapeuta podría preguntar algo así como: "¿Es usual que las cosas no hayan ido peor?" o "¿Cómo lo has hecho para evitar que las cosas empeoren?" Estas preguntas pueden conducir a información sobre las soluciones y las excepciones anteriores, y puede moverlos hacia un "hablar de soluciones *mode on*".

OBJETIVOS CENTRADOS EN SOLUCIONES

Al igual que muchos modelos de psicoterapia, el establecimiento de objetivos personales relevantes, claros, específicos y alcanzables son un componente importante de la TBCS. Siempre que sea posible, el profesional intenta evocar metas pequeñas en lugar de metas grandes. Más importante aún, se anima a las personas a definir sus metas en términos de la presencia de una solución, en vez de la ausencia de un problema. Por ejemplo, es mejor tener como meta: "Queremos que nuestro hijo nos hable con respeto", que tendría que ser descrito con mayor detalle, en lugar de, "Nos gustaría que nuestro hijo no nos grite." Además, el objetivo está enmarcado como algo que la persona puede practicar regularmente y que no depende de otro. Si un objetivo se describe en términos de su solución, se puede ampliar más fácilmente (ver más abajo).

Existen varias preguntas que se pueden formular para evocar objetivos en las personas/familias que consultan. Para generar objetivos de mediano plazo, por ejemplo, podemos preguntar: "Imagínese que viajamos al futuro cuando terminamos de verlo aquí, y las cosas están mejor ¿Cómo son las cosas?", en un plazo inmediato, pensando en el final de la sesión o en un plazo menor a una semana, se puede preguntar: "Imagínese que terminamos nuestra conversación de hoy y sientes que te sirvió, ¿cómo se da cuenta que sirvió?" o "Imagínese que llegamos al final de la sesión y usted se va con la sensación de que le sirvió lo que conversamos hoy ¿Cómo se da cuenta que le sirvió esta conversación?" o "¿Habrá alguna cosa que usted podría hacer de aquí a mañana que le sirva para avanzar hacia es imagen de futuro?, ¿alguna acción o algo que usted podría hacer de aquí a mañana?

PREGUNTA DEL MILAGRO

Algunos consultantes tienen dificultades para articular objetivos, y más aún metas centradas en soluciones. La pregunta del milagro es una manera de preguntar por el objetivo de una persona de una manera que comunica respeto por la inmensidad del problema, y al mismo tiempo la conduce a dar con las piezas más pequeñas y manejables de la meta. También es una manera para que muchos hagan un "ensayo virtual" de su futuro preferido.

El lenguaje preciso de la intervención puede variar, pero la redacción básica es: "Voy a hacerte una pregunta bastante extraña [pausa]. La extraña pregunta es la siguiente: [pausa] Después que hablemos, volverás a tu trabajo (el hogar, la escuela) y harás lo que tienes que hacer el resto del día, cosas como el cuidado de los hijos, cocinar la cena, ver la televisión, dar un baño a los niños, etc. Llegará el momento de ir a la cama. Todos en tu casa están tranquilos y duermes en paz. En el medio de la

noche, un milagro ocurre y el problema que te trajo a hablar conmigo ¡hoy está resuelto! Pero debido a que esto ocurre mientras usted está durmiendo, es que no hay manera de saber que hubo un milagro durante la noche que resolvió el problema. [pausa] Por lo tanto, cuando se despierta mañana por la mañana, qué podría ser el primer pequeño cambio que hará que te digas a ti mismo, '¡Guau! algo debe haber sucedido, el problema se ha ido!' "(Berg & Dolan, 2001, p. 7.)

Las personas tienen varias reacciones a la pregunta. Pueden parecer perplejos. Ellos pueden decir que no entienden la pregunta o que "no saben". Pueden sonreír. Por lo general, sin embargo, dado el tiempo suficiente para reflexionar sobre esta pregunta además de la persistencia del terapeuta, empiezan a aparecer algunas cosas que serían diferentes cuando el problema se resuelve. Presentamos aquí un ejemplo de cómo una pareja, ambos ex traficantes de drogas con varios años de contacto previo con los terapeutas y trabajadores sociales, que dijeron que querían a los "servicios sociales fuera de nuestras vidas" comenzó a responder a la pregunta milagro. Insoo Kim Berg es la entrevistadora. Además de ser un buen ejemplo de cómo los clientes comienzan respondiendo a la pregunta del milagro, estos extractos ilustran la co-construcción de TBCS entre la terapeuta y los usuarios, donde significados alterados o nuevos se construyen en la medida que la terapeuta formula las siguientes preguntas y respuestas sobre la base de las respuestas y las palabras anteriores de los clientes, aquí se muestra lo que va a ser diferente cuando el milagro suceda:

Berg: (Finalización de la pregunta del milagro con ...) Así que cuando te despiertas mañana por la mañana, cuál será la primera pequeña pista para ti ... "¡guau! algo es diferente".

Padre: ¿Quieres decir que todo se ha ido: los niños ... todo?

Mamá: No no.

Berg: El problema se ha ido.

Padre: ¿Nunca sucedió?

Mamá: El problema ocurrió pero todo es mejor.

Berg: Todo está controlado ahora.

Mamá: Si te digo la verdad, yo probablemente no sé cómo ... estamos esperando. Quiero decir, estamos a la espera de ese día. Estamos esperando el día en que sólo no hay nadie.

Iceberg: Nadie. No hay servicio social en su vida.

Mamá: Sí.

Iceberg: ¿Cómo lo…, cuando ustedes logran despertar en la mañana, y miran alrededor y ven, lo que le permitirá saber ... "guau, hoy es diferente, un día diferente hoy en día, algo es diferente, algo sucedió. "

Padre: La sensación de la tripa. El sentimiento interior. Sacarnos el mono de la espalda por así decirlo.

Berg: De acuerdo.

Padre: Cuando tuve un problema con las drogas..., supongo que era gran parte del tiempo el mismo sentimiento.

Cuando tuve el problema de drogas yo siempre estaba buscando, y justo siempre algo, nunca me sentí bien por ello. Ya sabes.
Berg: [Conecta con las palabras del consultante y significados, haciendo caso omiso de las "declaraciones de denuncia" y escoge una parte del mensaje del consultante que está conectada con aquello que ellos quieren sentir diferente] Así que, después de este milagro esta noche, cuando el milagro sucede, los problemas están resueltos, ¿que sería diferente en su sensación de tripa?
Padre: Tal vez me siento un poco más ligero, es un poco más fácil moverme... no tener que, ah, responder por cada uno de mis movimientos.
Mamá: UH Huh. Ser capaz de tomar decisiones como marido y mujer. Como padres de niños. Sin tener que preguntarse, "¿tomamos la decisión correcta o vamos a ser juzgados con esa decisión?"
Berg: Oh.
Mamá: Quiero decir, esto es lo que sentimos que es lo mejor, pero cuando tenemos que responder *nuestra* decisión a alguien más...
Padre: Sí, me refiero a "tratemos de esta manera," o "tratemos de esa manera," bueno, o sea, es natural aprender mucho de esas cosas por tu cuenta, o sea... quiero decir, tú te equivocas y te devuelves y lo intentas de otra manera.
Berg: Entonces, les gustaría tomar la decisión sólo ustedes dos, que ustedes dijeran: "hmm, esto tiene sentido, hagámoslo de esta manera", sin tener que preocuparse: "hay alguien que va a mirar por encima de nuestro hombro o no."
Mamá papá: Correcto.
Mamá: Y si estamos o no estamos de acuerdo. Tener a alguien, tener a alguien que tome partido, ya sabes, ¿cuál es su punto, cual es mi punto? Y después tratar de explicarnos a nosotros, bueno...
Padre: (Refiriéndose a los servicios sociales) Siempre fue tener un mediador, es decir...
Mamá: Sí, siempre hay alguien que media.
Berg: Entonces el mediador se habrá ido. Estará fuera de su vida.
Mamá papá: Correcto.
Berg: (Conexión de nuevo con las palabras del cliente / significados; aceptar y construir) OK Correcto. Correcto. Entonces, supongan, supongan que todos estos mediadores están fuera de su vida, incluyéndome a mí. ¿Qué sería diferente entre ustedes dos? (Silencio)
Padre: (Suspira)
Mamá: Todo. Como he dicho, ser capaz de mirarnos el uno al otro como marido y mujer y saber que si hemos, si estamos de acuerdo en algo, que esa es *nuestra* decisión, y esa es la forma en que va a ser. Si no estamos de acuerdo en algo, es una decisión que, quiero decir, eso es algo que tenemos que trabajar entre nosotros, y nosotros no tenemos que preocuparnos de cual va a ser la opinión de la tercera persona, y no tenemos que tener una tercera persona diciendo: "Sí, bueno, estoy de acuerdo, la manera en que Keith decidió que era correcta". Lo cual me hace sentir aún más menospreciado.

Berg: Muy bien. Entonces ustedes dos tomarán decisiones con respecto a su familia. Qué hacer con los niños, qué hacer con el dinero, lo que van a hacer con cualquier cosa, ¿cierto?
Mamá: Correcto.
Berg: Supongan que ustedes son capaces de hacer eso sin titubear. ¿Qué sería diferente entre ustedes dos... que les hará saber, "¡guau! ¡Esto es diferente! Estamos tomando nuestras propias decisiones".
Mamá: Una gran cantidad de tensión se va, creo
Y así sucesivamente…

Lo que las personas/familias son capaces de co-construir con el terapeuta, en respuesta a la pregunta del milagro generalmente se puede tomar como los objetivos de la terapia. Con una descripción detallada de cómo les gustaría que sus vidas sean, los consultantes pueden recurrir más fácilmente a la construcción de significados ampliados sobre excepciones y pasados comportamientos de soluciones que pueden ser útiles en la realización de sus futuros preferidos.

En la terapia de parejas, familias o grupos, la pregunta milagro puede hacerse de manera individual o grupal. Si se le pregunta individuamente, cada miembro daría su respuesta a la pregunta del milagro, y otros podrían reaccionar a ella. Si la pregunta se plantea a la familia, al grupo, o la pareja en su conjunto, los miembros pueden "trabajar en" su milagro juntos. El terapeuta centrado en las soluciones, al tratar de mantener una actitud de colaboración entre los miembros de la familia, enfatiza en las metas similares y afirmaciones de apoyo entre los miembros de la familia.

PREGUNTAS DE ESCALA

Cuando la persona o familia da metas específicas directamente o bien, a través de la pregunta del milagro, una siguiente intervención en TBCS es hacer que ellos evalúen su estado actual. Las preguntas de escala son posibles y útiles. En la primera sesión, preguntando en una escala de 1 a 10, qué tan dispuesta está la persona a realmente hacer algo para avanzar hacia su futuro preferido, es útil para evaluar la motivación para el cambio. También se les puede preguntar por su nivel de confianza para el logro de su objetivo en la misma escala de 1 a 10. El terapeuta puede preguntar la pregunta del milagro de escala: “En una escala de 1 a 10 donde 10 es esta imagen futura de (por ejemplo, felicidad) y 1 es lo peor que puede estar ¿en qué número se encuentra usted?” O “De 1 a 10, donde 1 significa que el momento en que tomo la hora para venir y 10 significa el día después del milagro, ¿dónde/cómo están las cosas ahora?” Por ejemplo, con una pareja donde una mejor comunicación es su objetivo:
Terapeuta: Lo que quiero hacer ahora es medir el problema y su objetivo. Digamos que un 1 es tan malo como el problema jamás podría ser, nunca se habla, sólo peleas, o evitar todo el tiempo. Y digamos que un 10 es donde se hable todo el tiempo, con una comunicación perfecta, nunca tienen una pelea.
Esposo: Eso es bastante poco realista

T: Eso sería lo ideal. Así que ¿dónde dicen ustedes que fue en el peor momento? Tal vez justo antes de venir a verme.
Esposa: Era bastante malo ... No sé ... yo diría que un 2 o un 3.
Marido: Sí, yo diría que un 2.
T: Ok (escribe) ... 2-3 para usted, y un 2 para usted. Ahora, díganme con que estarían satisfechos ustedes cuando la terapia se termine y sea exitosa?
E: Yo sería feliz con un 8.
M: Bueno, por supuesto que me gustaría un 10, pero eso es poco realista. Sí, estoy de acuerdo, un 8 sería bueno.
T: ¿Dónde dirían ustedes que están en este momento?
E: Yo diría que es un poco mejor, porque él viene aquí conmigo, y veo que él está tratando de... Yo diría que tal vez un 4?
M: Bueno, es bueno escuchar eso. Yo no habría pensado que ella habría puesto tan alto. Yo diría que es un 5.
T: Ok, un 4 para usted, un 5 para usted. Y ambos quieren que sea un 8 para que la terapia sea exitosa, ¿no?
Hay tres componentes principales de esta intervención. Primero, es un dispositivo de evaluación. Es decir, cuando se utiliza en cada sesión, el profesional y los consultantes tienen una continua medición del progreso de estos últimos. En segundo lugar, se deja en claro que la evaluación del consultante es más importante que la del terapeuta. En tercer lugar, esta es una poderosa intervención en sí misma ya que el diálogo se centra en soluciones y excepciones previas, enfatizando cualquier nuevo cambio que se produzca. Al igual que con la pregunta sobre los cambios realizados antes de la primera sesión, aquí hay tres cosas que pueden suceder entre cada sesión: (a) las cosas pueden mejorar, (b) las cosas pueden seguir igual, (c) las cosas pueden empeorar.
Si la balanza sube, el terapeuta evoca largas descripciones y detalles en cuanto a lo que es diferente y mejor, y respecto de cómo lograron hacer los cambios. El terapeuta puede elogiar/felicitar al cliente durante la sesión por los progresos realizados, o bien, puede comentar los cambios al final de la sesión a través de un resumen. Estas acciones apoyan y consolidan los cambios, y conducen al consecuente “empujoncito” para "hacer más de lo mismo." Si las cosas "están igual," una vez más, los usuarios pueden ser reforzados por el mantenimiento de sus cambios, o por no permitir que las cosas se pongan peor. El terapeuta puede preguntar "¿Cómo lo has hecho para no estar peor?" Es interesante la frecuencia con la que esta pregunta puede llevar a una descripción de los cambios que los usuarios han hecho, en tal caso, una vez más, el terapeuta puede elogiar/felicitar, apoyar y animar a hacer más de lo que está haciendo, y por ende, continuar con el cambio.
T: María, la semana pasada tú estabas en un 4 en la escala de la buena comunicación. Me pregunto dónde te encuentras esta semana.
E: [pausa] yo diría que un 5.
T: Un 5! ¡Guauu! En serio! en sólo una semana.
E: Sí, creo que nos hemos comunicado mejor esta semana.

T: ¿Cómo te comunicaste mejor esta semana?
E: Bueno, creo que fue Rich. Parecía tratar de escucharme más esta semana.
T: Eso es genial. ¿Me puedes dar un ejemplo de cuando él estuvo escuchando más?
E: Bueno, sí, ayer por ejemplo. Por lo general me llama una vez al día desde el trabajo, y ...
T: Siento interrumpir, pero dijiste que él te llama una vez al día? ¿Desde el trabajo?
E: Sí
T: Estoy un poco sorprendida, porque no todos los maridos llaman a sus esposas cada día.
E: Él siempre ha hecho eso.
T: ¿Eso es algo que te gusta? Algo que no quisieras que cambie?
W: Si, por supuesto.
T: Disculpa, continúa, me estabas contando de ayer cuando Rich llamó.
E: Bueno, por lo general es una especie de llamada corta. Pero le dije acerca de algunos problemas que estaba teniendo, y él escuchó por harto rato, parecía que le importaba, me dio algunas buenas ideas. Eso me gustó.
T: Entonces, ¿ese fue un ejemplo de cómo le gustaría que fuera, donde se puede hablar de algo, un problema, y él escucha y da buenas ideas? ¿Apoyo?
E: Sí.
T: Rich, ¿sabía usted que a María le gusta que usted la llame y la escuche? ¿Y que eso hizo que ustedes dos asciendan en la escala, para ella?
M: Si, supongo. He estado tratando realmente esta semana.
T: Esto es genial. ¿Qué más han hecho ustedes para tratar de mejorar la comunicación esta semana?

Este ejemplo muestra que avanzar en la escala con la pareja sirve como un medio para encontrar progreso en los consultantes. La terapeuta obtuvo más y más información sobre los pequeños cambios que los usuarios hicieron por su cuenta, utilizando las diferencias en la escala para generar preguntas. Naturalmente, esto llevó a la profesional a sugerir que la pareja siga haciendo las cosas que estaban resultando bien, en el caso del marido, continuar llamándola y seguir involucrándose en la escucha activa que ella encontró tan útil.

LA CONSTRUCCIÓN DE SOLUCIONES Y EXCEPCIONES

El profesional centrado en soluciones pasa la mayor parte de la sesión escuchando atentamente a soluciones previas, excepciones y objetivos. Cuando éstos aparecen, el profesional los enfatiza con entusiasmo y apoyo. Luego trabaja para mantener la "conversación sobre soluciones" en la palestra. Esto, por supuesto, requiere de toda una serie de habilidades diferentes a las utilizadas en las terapias tradicionales centradas en los problemas. Mientras que el terapeuta centrado en el problema se preocupa por los signos latentes de lo que ha causado o mantiene un problema, el profesional centrado en las soluciones está preocupado por los signos latentes de progreso y soluciones.

Madre: Ella siempre me ignora, actúa como si no estuviera allí, llega a casa de la escuela, simplemente corre a su cuarto. Quién sabe lo que está haciendo ahí.
Hija: Usted dice que peleamos todo el tiempo, así que me voy a mi habitación, para que no peleemos.
M: ¿Ve? Ella admite que solo trata de evitarme. No sé por qué no puede solo volver a casa y hablar conmigo un poco, acerca de la escuela o algo así, como solía hacerlo.
T: Espera un segundo, ¿cuándo ella "solía hacerlo"? Anita, ¿cuándo solías volver a casa y contarle a tu madre acerca de la escuela?
H: Lo hice mucho, el semestre pasado pasó.
T: ¿Me puedes dar un ejemplo de la última vez que hiciste eso?
M: Yo te puedo decir, que fue la semana pasada en realidad. Y ella estaba muy emocionada porque su proyecto de ciencias fue elegido.
T: Cuénteme más, ¿qué día fue ese...?
M: Creo que el miércoles pasado.
T: Y ella llegó a casa ...
M: Ella llegó a casa muy emocionada.
T: ¿Que estabas haciendo?
M: Creo que lo de costumbre, estaba preparando la cena. Y ella entró toda emocionada, y le pregunté qué pasaba, y me dijo que su proyecto de ciencias había sido elegido para la exhibición en la escuela.
T: guau, eso es todo un honor.
M: Lo es.
T: Entonces, ¿qué pasó?
M: Bueno, hablamos de ello, ella me lo contó todo.
T: Anita, ¿te acuerdas de esto?
H: Claro, fue sólo la semana pasada. Yo estaba muy feliz.
T: Y ¿ustedes dirían que esa fue una buena conversación, una buena conversación entre ustedes dos?
H: Por supuesto. Eso es lo que quiero decir; No siempre me voy a mi habitación.
T: ¿Había algo diferente en ese momento, de la semana pasada, que hizo más fácil que hablen entre ustedes?
M: Bueno, ella estaba emocionada.
H: Mi mamá me escuchó, no estaba haciendo otra cosa.
T: Guau!, esto es un gran ejemplo. Gracias. Déjenme preguntarles esto: si fuera así más a menudo, donde Anita hablara con usted acerca de las cosas que fueran interesantes e importantes para ella, y donde mamá, usted la escuchara por completo sin hacer otras cosas, ¿es eso a lo que ustedes se refieren con mejor comunicación?
H: Si exacto.
M: Sí

En este ejemplo, la profesional hizo varias de cosas. En primer lugar, ella puso atención a una excepción al problema, un momento en que el problema pudo haber sucedido, pero no ocurrió. En segundo lugar, hizo énfasis en esa excepción

repitiéndola, haciendo hincapié en ella, obteniendo cada vez más detalles al respecto, y felicitándolas por ello. En tercer lugar, conectó la excepción con su objetivo (o milagro) haciendo la pregunta: "¿es eso a lo que ustedes se refieren con mejor comunicación?"

PREGUNTAS DE AFRONTAMIENTO

Este tipo de preguntas también ha sido llamada por De Jong and Berg (2013) como un tipo de elogios indirectos, pues a través de su respuesta la persona enunciará sus propias fortalezas o logros. Si una persona informa que el problema no está mejor, el terapeuta pregunta: "¿Cómo lo has hecho para que las cosas no estén peor?" Incluso, si una persona informa que las cosas están mejor el profesional puede también formular una pregunta de afrontamiento: "¿Qué han hecho o cómo lo han hecho para lograr que las cosas estén así de bien?"

TOMAR UN DESCANSO Y VOLVER A REUNIRSE

Muchos modelos de terapia familiar han animado a los profesionales a tomar un descanso hacia el final de la sesión. Por lo general, esto consiste en una conversación entre el profesional y un equipo de colegas o un equipo de supervisión que ha estado observando la sesión y que dan retroalimentación y sugerencias al profesional. En TBCS, también se alienta a los profesionales a tomar un descanso cerca del final de la sesión. Si hay un equipo, ellos retroalimentan al profesional, dan una lista de elogios para la familia, y algunas sugerencias para las intervenciones basadas en las fortalezas del consultante, soluciones anteriores o excepciones. Si no hay un equipo disponible, el profesional aún puede tomar un descanso para recopilar sus reflexiones sobre la sesión, y luego llegar a los elogios e ideas para posibles tareas/experimentos. Cuando el profesional vuelve a la sesión puede entregar sus elogios a la familia.

T: Yo sólo quería decirles que el equipo estuvo muy impresionado con ustedes dos esta semana. Ellos querían que yo les diga lo siguiente, mamá: ellos pensaron que usted parece realmente preocupada por su hija. Es muy difícil ser mamá, y usted parece tan enfocada y clara acerca de lo mucho que la quiere y cómo la quiere ayudar. Ellos también quedaron impresionados de que haya venido a la sesión de hoy, a pesar del trabajo y tener un hijo enfermo en casa. Anita, el equipo también ha querido felicitarte por tu compromiso para hacer que la familia esté mejor. Querían que te diga lo brillante y elocuente que ellos piensan que tú eres, y ¡qué buena "científica" eres! Sí, que parece que estás realmente consciente de que pequeñas cositas que ocurren en tu familia podrían hacer una diferencia... Eso es lo que hacen los científicos, ellos observan los detalles que parecen provocar cambios en las cosas, no importa cuán pequeño sea. De todos modos, ¡se quedaron muy impresionados con ustedes dos!

H: [Mostrandose complacida] ¡guau, gracias!

EXPERIMENTOS Y TAREAS

Mientras muchos modelos de psicoterapia usan tareas entre sesiones para solidificar cambios iniciados durante el tratamiento, la mayoría de las veces la tarea es asignada por el profesional. En la TBCS, los profesionales a menudo terminan la sesión sugiriendo un posible experimento para que las familias o personas prueben entre sesiones, si así lo desean. Estos experimentos se basan en algo que ellos ya están haciendo (excepciones), pensando, sintiendo, etc. y que les está ayudando a avanzar hacia su objetivo. Como alternativa, la tarea puede ser diseñada por el sujeto de intervención. Ambas opciones siguen la filosofía básica de que lo que emerge desde el sujeto es mejor que lo que pueda emerger desde el terapeuta. Esto se debe a varios motivos. En primer lugar, lo que usualmente sugiere la persona que consulta, directa o indirectamente, es significativo. Una de las principales razones de por qué la tarea no se logra en otros modelos es que es ajena a la familia, por lo que toma más procesamiento y trabajo para llevarse a cabo (generalmente considerado como "resistencia"). En segundo lugar, las personas suelen asignarse a sí mismas ya sea más de lo que ha resultado positivo para ellos (una solución anterior) o algo que realmente quieren hacer. En ambos casos, la tarea está más ligada a sus propios objetivos y soluciones. En tercer lugar, cuando una persona realiza su propia tarea, se reduce la tendencia natural del ser humano a "resistir" la intervención externa, no importando si la intención es buena o no. Mientras la TBCS no se centra en la resistencia (de hecho, considera este fenómeno como un proceso natural, protector que la gente usa para moverse lentamente y con cautela más que como una prueba de la psicopatología), cuando los clientes comienzan a hacer su propia tarea, hay una mayor probabilidad de éxito.

T: Antes de terminar hoy, me gustaría que ustedes dos piensen en una tarea. Si tuvieran que darse a sí mismos una tarea de esta semana, ¿cuál sería?
H: ¿Tal vez que hablemos más?
T: ¿Puedes decirme más de eso?
H: Bueno, que yo trate de hablar con ella más cuando llegue a casa desde la escuela. Y que ella deje de hacer lo que está haciendo y me escuche.
T: Me gusta eso. ¿Sabes por qué? Debido a que es lo que ustedes dos estaban empezando a hacer la semana pasada. Mamá, ¿qué te parece? ¿Eso es una buena tarea?
M: Si, eso está bien.
T: Entonces, hagamos el acuerdo. Anita va a tratar de hablar más con usted cuando ella llega a casa de la escuela. Y usted va a dejar lo que está haciendo - si se puede- y escuchar y hablar con ella acerca de lo que ella está hablando con usted. ¿Algo más? Hay algo que quieran agregar?
M: No, eso es bueno. Sólo tengo que dejar de hacer lo que estaba haciendo, creo que es importante escucharla a ella.
T: Bueno, eso seguro parecía funcionar para ustedes dos la semana pasada. De acuerdo, así que esa es la tarea. Vamos a ver cómo les ha ido la próxima vez.

Dos puntos a enfatizar: En primer lugar, se le pidió a la madre y la hija crear su propia tarea en lugar de que la terapeuta imponga una. En segundo lugar, lo que ellas se asignaron fluyó naturalmente de sus soluciones y excepciones de la semana anterior. Esto es muy común y es alentado por los profesionales centrados en las soluciones. Sin embargo, incluso si la familia sugiriera una tarea, que no se basa en soluciones y excepciones al problema, lo más probable es que el terapeuta lo apoye. Lo importante de esta parte es que las tareas provengan desde las personas o familias asistidas en terapia.

En los casos en que la persona no ha sido capaz de formar un objetivo claro el terapeuta puede sugerirle que piense acerca de cómo quiere que las cosas sean, por ejemplo, mediante la fórmula de tarea de la primera sesión (first session formula-task; de Shazer, 1992, 1994). La forma genérica de la fórmula es: "Observe qué cosas están pasando en su vida y que están relacionadas con su venida aquí que desea que continúen pasando, desde ahora a nuestra próxima sesión." Otro ejemplo de tarea que sugiere observar lo que funciona es: “De aquí a la próxima sesión quiero que se fije en las cosas que le sirven a usted, en esos pequeños pasos que le ayuden a avanzar hacia lo que usted quiere y vea qué pasa”. Ideas acerca de lo que el terapeuta piensa que pueden ser útil para la persona o familia pueden, y a menudo, deben darse con el mensaje de cierre de la sesión. Estos tendrán algo que ver con lo que el cliente describe en el milagro.

SEGUNDA SESIÓN Y SIGUIENTES: ENTONCES, ¿QUÉ ES MEJOR, AUNQUE SEA UN POCO, DESDE LA ÚLTIMA VEZ QUE NOS VIMOS?

Al comienzo de cada sesión después de la primera, el profesional suele preguntar sobre el progreso, acerca de lo *que ha estado mejor durante el intervalo*. Muchas personas cuentan que ha habido algunas mejoras notables. El profesional le pedirá que describa estos cambios con el mayor detalle posible. Algunas personas cuentan que las cosas han permanecido igual o que han empeorado. Esto llevará a que el profesional explore cómo la persona lo ha hecho para que las cosas no estén cada vez peor; o, si es peor, qué hizo para evitar que las cosas sean aún peor (*preguntas de afrontamiento*). Lo que quiera que la persona haya hecho para evitar que las cosas empeoren será entonces el foco y fuente de elogios y, tal vez, insumo para un experimento, pues eso es lo que les ha funcionado bien para no estar peor. Durante la sesión, por lo general después que ha habido bastante tiempo destinado a conversar acerca de lo que está mejor, el profesional le pregunta a la persona cómo evaluaría su progreso (hacia la solución) en la *escala de 1 a 10*. Por supuesto, cuando la calificación es más alta que la sesión anterior el terapeuta *felicitará* estos avances y ayudará a que los consultantes elaboren cómo van a *mantener* la mejora.

En algún momento durante la sesión, el profesional chequeará, con frecuencia indirectamente, sobre cómo les fue con la tarea. Si el consultante hizo la tarea, y ésta "resultó" -es decir, la tarea efectivamente ayudó a avanzar hacia su futuro preferido el profesional felicita a la familia/persona. Si ellos no hicieron su tarea, el profesional desecha la tarea y puede preguntar qué hizo a la

persona/familia en lugar de la tarea que sí dió un buen resultado y que por lo tanto fue una mejor alternativa.

Una diferencia entre la TBCS y otros modelos que son orientados a la tarea, como la terapia cognitivo-conductual, es que la propia tarea no es necesaria para el cambio en sí, por lo que no completar una tarea no se aborda, ni se trata de indagar que pasó que hizo que la persona/familia no haga la tarea. Si la persona/familia no hace la tarea, se supone que ellos tienen buenas razones, tales como (a) algo realista obstaculizó su realización, como el trabajo o una enfermedad; (b) la persona/familia no la encontró útil o (c) básicamente, no era algo relevante durante el intervalo. En cualquier caso, no se considera una falta el no hacer la tarea. Si la persona hizo la tarea, pero las cosas no mejoraron o empeoraron, el terapeuta maneja esto de la misma forma en que lo haría si los problemas permanecieran igual o empeoraran.

Características y requisitos del profesional centrado en las soluciones

Los profesionales centrados en las soluciones deben poseer la formación necesaria y la certificación en una disciplina de la salud mental y formación especializada en TBCS. El profesional ideal debiera poseer (a) un título profesional de una disciplina de ayuda como consejería, trabajo social, terapia matrimonial y familiar, psicología, o psiquiatría; (b) capacitación formal y supervisión en la terapia breve centrada en soluciones, ya sea a través de clases en la universidad o de una serie de talleres y experiencias de formación, así como la supervisión en sus contextos de trabajo. El profesional que se maneja y sobresale como terapeuta centrados en las soluciones, tiene estas características: (a) es cálido y amable; (b) es naturalmente positivo y apoyador (a menudo se le dice que "ven lo bueno en la gente"); (c) son de mente abierta y flexible a nuevas ideas; (d) son excelentes escuchadores, especialmente con la capacidad de escuchar soluciones anteriores en los clientes encerrados en la "conversación sobre problemas"; y (e) son tenaces y pacientes.

Formación del Terapeuta

Los profesionales que cumplan con los requisitos anteriores deben recibir capacitación formal y supervisión en TBCS. Una breve reseña de un programa de formación incluiría:

1. Historia y filosofía de la TBCS
2. Los principios básicos de la TBCS
3. Formato de la sesión y estructura de la TBCS
4. Ejemplos filmados de "maestros" de la TBCS
5. Formato de la TBCS
6. Ejemplos filmados de TBCS
7. Juego de roles
8. Práctica con retroalimentación de vídeo

9. Entrenamiento con retroalimentación de vídeo

Los profesionales pueden considerarse capacitados cuando logren una calificación de adhesión y competencia de un 85% usando escalas de evaluación estandarizadas de adherencia y competencias. También debe haber evaluaciones subjetivas por parte de los formadores como a la capacidad global de los profesionales para funcionar de forma fiable y competente como profesionales centrados en las soluciones.

Supervisión

Los profesionales centrados en las soluciones deben ser supervisados en directo siempre que sea posible. Uno de los problemas más comunes del profesional es volver a caer en "hablar de problemas." Es mucho mejor que el profesionl en formación reciba retroalimentación simultánea, a través del teléfono con llamadas en directo, por ejemplo, para que esto pueda ser corregido inmediatamente. Es mucho más probable que la "conversación sobre soluciones" se convierta en algo natural y cómodo para los profesionales cuando se les da una retroalimentación inmediata, especialmente al principio de la formación. La otra ventaja de vivir la supervisión, por supuesto, es que hay un segundo conjunto de "ojos clínicos", de los cuales también se beneficiarán los usuarios, sobre todo los casos más difíciles. Cuando la supervisión en vivo no es posible, la supervisión en video es una alternativa, ya que el movimiento y el lenguaje corporal es relevante para la retroalimentación que el supervisor dará al terapeuta. Escalas de adherencia y de competencia deben ser utilizadas como un complemento a la supervisión, para enfocar la supervisión en equilibrar tanto la cantidad de intervenciones (adherencia) y la calidad (competencia) y permitir la reparación más inmediata.

CAPÍTULO 3: TBCS Y PERSONAS QUE PRESENTAN TRASTORNOS DEL USO DE ALCOHOL

Cultura "Chilensis"

El consumo de alcohol en Chile alcanzó el más alto porcentaje de consumo de alcohol per cápita en Latinoamérica con 13,9 litros en hombres y 5,5 litros en mujeres al año. La última Encuesta Nacional de Salud (Ministerio de Salud, 2011) informó que el 74% de la población igual mayor de 15 años consumió alcohol durante el año anterior, un 57% consumió alcohol durante el mes anterior y un 36%, durante la semana anterior. Lo grave es que en este último grupo, más del 98% tuvo episodios de consumo excesivo, en un promedio de 88.4 gramos de alcohol puro, cuando el límite de consumo de alcohol considerado moderado por la OMS es de menos de 50/60 (mujeres/hombres) gramos en una ocasión (OMS, 2014).

Se cree que entre las principales razones del alto consumo de alcohol en nuestro país está el hecho de que Chile es un gran productor de vino (OMS, 2014) y que existen variadas festividades tradicionales que se encuentran culturalmente asociadas al uso de alcohol y que son ampliamente toleradas (Griesbretch et al., 2013), lo cual también se refleja a lo largo y ancho de Latinoamérica (Monteiro, 2007; Pew Research Center, 2014; Sojo, 2012). Un estudio respecto de actitudes valóricas en varios países del mundo mostró que en Chile, el 31% de la población estuvo de acuerdo con la afirmación de que es "moralmente malo" consumir alcohol (Pew Research Center) lo cual se condice bastante bien con el porcentaje de consumo reflejado en la última Encuesta Nacional de Salud.

Como complemento a esta información de la población en general, en un estudio previo a la construcción de este capítulo, que busca recoger algunos aspectos culturales del beber en la población chilena en sectores populares, se pudo conocer algunos aspectos relevantes que pueden ayudar a comprender la población con la que trabajamos.

Entre los principales hallazgos, se hizo evidente que usualmente los hombres beben en mayor cantidad que las mujeres y que las mujeres prefieren tragos más suaves que los hombres. Sin embargo, también sabemos que estas diferencias han disminuido a través de las generaciones y mujeres más jóvenes beben en mayores cantidades que mujeres mayores y, por ende, la diferencia en cantidad de alcohol consumida ha disminuido entre los géneros. Pese a estas similitudes experimentadas en las generaciones más jóvenes, existe la percepción generalizada de que es mal visto que las mujeres beban alcohol en exceso y que esto es aún peor si es en público. Esta visión contrasta con la valoración que se hace del beber en los hombres, la cual es normalizada por ser considerada más común.

En relación con el contexto comunitario, los proveedores de alcohol son usualmente las botillerías de barrio y luego los supermercados, sin embargo, cuando ninguno de éstos está disponible (horario nocturno) existen los negocios clandestinos, llamados picadas a los que sólo los hombres pueden ir. Por otra parte,

hay lugares en donde se puede beber y lugares donde no se puede beber. Respecto de aquellos en donde se puede beber, nuevamente existe mayor libertad para los hombres, quienes pueden beber en la casa, lugares públicos o la calle. En cambio, las mujeres no deben beber en lugares abiertos como plazas, parques o la calle. Existe un acuerdo generalizado de que hay lugares donde no se debe beber, tales como, las iglesias, el trabajo, los hospitales, en frente de los niños y mientras se maneja.

La familia cumple varios roles importantes en el consumo de alcohol pues puede ser el contexto en el cual se consume alcohol, siendo considerada por algunos como un espacio seguro donde beber sin exponerse a asaltos o accidentes. Sin embargo, también se reconoce que la familia es negativamente afectada cuando uno de sus miembros bebe en exceso, pues la persona tiende a ser agresiva y puede provocar daños emocionales y materiales. Por otra parte, la familia es una fuente de apoyo cuando las personas quieren o necesitan detener el consumo, siendo las figuras femeninas quienes cumplen un rol destacado en la provisión de este apoyo. Las mamás o las hijas suelen ser un pilar importante para las personas que consumen alcohol. No obstante lo anterior, también se reconoce que hay algunos casos en los que las familias no constituyen un buen apoyo, como por ejemplos en casos en los que existe delincuencia u otros factores de riesgo que pudieran contribuir con el aumento del consumo en lugar de la rehabilitación. En casos en los que la familia no constituye una fuente de apoyo, también es importante considerar otras personas significativas o importantes que no forman parte de la familia, tales como amigos o vecinos. Ellos lo definen como *seres queridos* que no necesariamente son familiares.

Alineados con la postura de la TBCS del profesional "no experto", estos hallazgos sólo sirven como una guía general y no como un pre-supuesto acerca de la cultura de cada persona o familia con la que trabajemos. Sin embargo, hubo un hallazgo llamativo que hace sentido con el espíritu de la TBCS y que forma parte de la adaptación lingüística-cultural del modelo. Las personas señalan que los profesionales que realizan intervenciones para el consumo de alcohol debiesen conversar acerca de las cosas que son importantes para el bebedor y las razones que hacen que él haya decidido venir. Este hallazgo refuerza y reafirma el potencial valor que la TBCS puede tener para intervenir con personas que consumen alcohol en exceso. De esta manera, la postura del "no experto" y la curiosidad genuina por saber qué es lo que la persona realmente quiere es una ventaja que este modelo presenta para poder trabajar con consumidores de alcohol chilenos.

TBCS y uso de alcohol

La TBCS ha sido calificada como una práctica basada en la evidencia para el tratamiento del consumo de sustancias, en especial a la luz de estudios con personas que consumen alcohol en los EE.UU. (Smock et al., 2008) y también en Europa (De Schazer & Isebaert, 2004). En México, el modelo se aplicó con personas que

consumían alcohol y tuvo un mayor efecto en personas con problemas más severos (Cordero et al., 2009).

El intervenir usando el modelo de la TBCS con personas que han sido detectadas con algún grado de severidad en el consumo del alcohol podría ser considerado contradictorio debido a que, como hemos visto en los capítulos anteriores, la TBCS tiene una postura despatologizadora. Sin embargo, esta perspectiva sí se puede aplicar en contextos donde las lógicas de operación son patologizantes. Por otra parte, la TBCS al adoptar el lenguaje que los usuarios tienen y la lógica que ellos tienen para referirse al uso de alcohol también respeta sus creencias y modos de ver el consumo de alcohol. En este sentido, el proceso involucra que la persona en tratamiento haga suya la idea de que su solución es mucho más que sólo reducir o dejar de beber alcohol. Por lo tanto, el profesional apoya a encontrar otros aspectos de su vida que se transformarán en sus objetivos y soluciones (De Shazer & Isebaerg, 2003; Pichot & Smock, 2009). De este modo, los objetivos relacionados con el consumo de alcohol son un medio para alcanzar objetivos definidos por la persona que acude a solicitar ayuda (Hendrick, Isebaert, & Dolan, 2012).

En esta línea, y como toda intervención posee un horizonte normativo, éste será co-construido con la persona o familia que consulta en relación o con referencia a otros sistemas que les rodean y que constituyen agentes normativos para quien consulta. Es aquí donde el clásico enfoque ecológico nos vuelve a servir como marco de referencia. Las preguntas relacionales son descritas por De Jong y Berg (2013) y permiten evocar descripciones de situaciones en las cuales las personas crean significados y soluciones. Por ejemplo, " Quién podría notar que las cosas están mejor?" o "¿Qué tendrían que ver sus padres, su señora, el juzgado, la escuela, etc., para que ellos crean que usted ya no tiene un problema con el alcohol?" Estas preguntas trabajan en esta co-construcción. El ejemplo que sigue fue traducido y adaptado del libro de Pichot y Smock (2009, p. 77-78) Solution-Focused Substance Abuse Treatmet (Tratamiento para el Abuso de Substancias Centrado en las Soluciones).

Terapeuta: Entonces, ¿cómo lo puedo ayudar hoy?
Consultante: La asistente social de la OPD cree que tengo un problema con el alcohol.
T: ¿y qué cree usted?
C: Yo no creo que tenga un problema, pero no puedo recuperar a ms hijos hasta que ella cambie de opinión.
T: ¿Y qué tendría que ver ella en usted que le haga saber que usted no tiene un problema con el alcohol?
C: Ella vería que estoy trabajando, que llego puntual a las horas, que hay comida en la casa, usted sabe. Todas esas cosas.
T: ¿eso sería diferente a como es hoy?
C: Sí y no. Sería diferente para mí llegar a la hora e ir al trabajo.
T: ¿y qué sería diferente que le ayudaría a que usted pueda lograr hacer estas cosas?

C: Yo descansaría lo suficiente y podría levantarme a tiempo.
T: ¿y cómo habría hecho eso?
C: Probablemente no habría carreteado la noche anterior.
T: ¿Qué habría hecho entonces?
C: Tal vez sólo **estar con los niños**, tal vez **jugar con ellos** o algo así…

Tal como se ha mostrado en los capítulos anteriores, aquí el profesional ayuda al consultante a co-construir lo que podría ser su solución a través de preguntas relacionales centradas en el futuro. En este caso, usa la imagen de la asistente social de la OPD como quien define el horizonte normativo para recuperar a sus niños, sin embargo, finalmente, la definición de la solución es elaborada por la persona y no, la asistente social de la OPD ni el terapeuta: "estar con los niños, jugar con ellos". De este modo, el terapeuta podría seguir construyendo con una próxima pregunta y/o respuesta que construya sobre esta última frase, usando las palabras claves dadas por la persona consultante.

En el caso de recibir a una persona que estaba en abstinencia de consumo o que estaba alcanzando una meta de consumo no excesivo en una segunda o tercera sesión que ha recaído, tal como se señala en el capítulo 2 en las sección "experimentos y tareas" y "segunda sesión y siguientes", esta situación "no se aborda" directamente. De esta manera, el profesional nuevamente escucha atentamente por excepciones al problema, recursos y estrategias de afrontamiento, los selecciona y construye sobre ello. El siguiente ejemplo fue traducido y adaptado desde (Pichot & Smock, 2009, p. 41).
Terapeuta: ¿Cómo le puedo ayudar?
Consultante: Tuve una recaída esta semana. Ha sido terrible.
T: Siento mucho escuchar eso… Pero igual, estoy muy contenta que usted haya llegado aquí a nuestra cita. ¿Cómo lo hizo para parar de beber y poder venir conmigo?
C: Yo sólo sabía que tenía que venir.
T: ¿Es distinto para usted ser capaz de parar cuando usted sabe que hay algo que tiene que hacer?
C: ¡Oh sí! Usualmente me mantengo bebiendo y pienso, "bueno, ya la embarré, así que sigo tomando".
T: ¡Pero no lo hizo esta vez!
C: No.
T: ¿Cómo se detuvo?

En este ejemplo, el terapeuta reconoce y valida el sentimiento "terrible" que tiene la persona que consulta respecto de su recaída; sin embargo, no pregunta qué pasó ni indaga mayormente en ese sentirse "terrible", sino que directamente cambia de foco y formula dos cosas: Primero, un *elogio o refuerzo* por el hecho de haber concurrido a la cita pese a la recaída y a que se siente "terrible". Segundo, una pregunta de afrontamiento a partir de la cual obtiene información relevante acerca de una *excepción* al comportamiento típico del cliente, lo cual da paso a otra pregunta de afrontamiento tan simple como ¿cómo se detuvo? Probablemente, la

respuesta que obtendrá el profesional serán *fortalezas, recursos y estrategias* que sirven para co-construir soluciones.

Appendix E: Intervention Protocol for Three SFBT Sessions.

Guía de Intervención Centrada en Soluciones para personas con uso de alcohol problemático
Trabajadores Sociales en Atención Primaria

Por Karla González Suitt
Marzo, 2016

Esta guía ha sido creada para implementar tres sesiones (o más) de Terapia Breve Centrada en Soluciones (TBCS) por trabajadores sociales de la atención primaria de salud con personas que presentan problemas con el consumo de alcohol con un puntaje igual o mayor que 8 según el instrumento AUDIT. Se usará en el marco de la investigación "Adaptación cultural de la TBCS a población Chilena: un estudio piloto." La guía debe usarse una vez estudiado el manual de Terapia Breve Centrada en Soluciones, el cual explica cada una de las intervenciones que componen el modelo de intervención.

Sesión 1

Antes de la sesión, asegurarse de tener los siguientes materiales:			
Grabadora	O	Encuesta de Cita	O
Check list	O	Registro de sesión	O

*****RECORDAR QUE LA SESION SERA GRABADA** Y SI ES QUE SERÁ SUPERVISADO PEDIR CONSENTIMIENTO PARA ELLO.***

BIENVENIDA:

Usar preguntas de bienvenida en siguiente orden:

¿En qué puedo ser útil hoy?

Puede que aparezca tema de consumo de OH. Si aparece, bien y si no, bien también ☺

CAMBIO PRE-SESION:

¿Qué cosas han estado mejor desde que usted tomó la hora conmigo hasta ahora?

Es posible que consultante responda cosas que han estado mejor, o que diga "nada" o que diga que las cosas han estado "peor". Si dice "nada" o "peor", continuar con la siguiente intervención, si en cambio dice cosas que han estado "mejor", AMPLIAR:

¿En qué nota que las cosas están mejor?

¿Qué cosas hace usted cuando las cosas están mejor?

¿Quién más se da cuenta?

ETC

¿Qué tendría que pasar en esta sesión para que al final de nuestra conversación usted sienta que valió la pena que conversemos?

PREGUNTA CENTRADA EN EL FUTURO PARA DESCUBRIR OBJETIVO DE INTERVENCION (escoger una o crear una similar):

Imagínese como serían las cosas en su vida si el problema que la trajo aquí no existiera más ¿Cómo sería?

Imagínese que el problema ya pasó y todo está muy bien… ¿cómo se lo imagina?

Preguntar por detalles, como se ve usted, que está haciendo, quien más lo ve, que opina el resto, etc…

Resumir la imagen futura tomando las palabras del consultante.

BÚSQUEDA DE EXCEPCIONES:

Si ha aparecido tema de consumo de OH, podemos preguntar:

¿Ha habido veces en que siente que estuvo al menos un poquito mejor respecto del consumo de_____ *(usar la palabra que la persona use: copete, trago, cerveza, chela, etc.)*?

Ojo si es mujer. Puede que se sienta muy estigmatizada o que se sienta muy avergonzada o culpable, autoestima baja, etc. Empatizar, normalizar en términos de que a todas nos puede pasar, externalizar siempre.

Si no ha aparecido tema de consumo de OH, preguntar:
¿Ha habido veces en que siente que estuvo al menos un poquito mejor respecto de_____ (lo que ellos planteen como problema)?
PREGUNTAS DE AFRONTAMIENTO:
¿Cómo lo hizo para estar mejor?
Y/o
¿Cómo se da cuenta que las cosas están mejor?
PREGUNTAS DE ESCALA: elegir la que les quede más cómoda (o crear una similar).
Si yo le dijera que tiene que elegir un numero entre 1 y 10, donde 10 es que no existe ningún problema y 1 es lo peor que podría pasar ¿en qué número está hoy?
Pensemos en una escala de 1 a 10 donde 10 es la vida sin problemas y 1 es lo peor que podría estar ¿en qué número se encuentra hoy día?
PREGUNTA DE AFRONTAMIENTO:
¿Cómo lo hace/como lo ha hecho usted para estar en ese número y no más bajo?
PREGUNTAS DE RELACION:
¿Quién podría notar (quien se daría cuenta) que las cosas están mejor? (POR QUÉ, COMO , CUANDO, QUE MÁS)
¿En qué número de la escala *cree usted* que las otras personas dirían que usted está?
¿Por qué crees tú que ellos dirían que estas en ese nivel? (DE QUÉ MANERA LES AFECTA?)
¿Cómo ellos se dan cuenta que usted está en ese número y no más bajo?
PREGUNTA CENTRADA EN EL FUTURO: CONSTRUCCION DE OBJETIVOS Y TAREAS A CORTO PLAZO:
De aquí a una semana:
Imagínese que viajamos a una semana después […] y las cosas están mejor ¿en qué número de la escala que hemos conversado se pondría usted?
Si estuvieran un poquito mejor las cosas de aquí a una semana, ¿en qué número estaría usted?
Fin de la sesión
Imagínese que estamos al final de la sesión y usted se va a su casa con la sensación que esta conversación fue útil, ¿cómo nota que fue útil?
24 horas
Piense en una cosa que usted podría hacer de aquí a mañana que le ayudaría en avanzar hacia ese xx que usted quiere.
¿Habrá alguna cosa que usted podría hacer de hoy día a mañana que le sirva para avanzar desde ese número hacia este 10… algo que usted podría hacer de aquí a mañana?
¿Qué podría ser una cosa que usted haga, dentro de las próximas 24 horas, que le ayude a estar mejor/avanzar?
BREAK
Quiero pedirle que nos tomemos unos minutos. Necesito resumir y ordenar lo que hemos conversado para luego darle algunas sugerencias y ver como seguimos para la próxima sesión. ¿Le parece? (ver si persona espera afuera o salir de la sala).
En este tiempo de alrededor de 5 minutos:

- hacer un listado de elogios tomando en cuenta todas las fortalezas y recursos de la persona/familia.
- revisar si es que amerita dar alguna tarea concreta en función de las respuestas que la persona elaboró con las preguntas centradas en el futuro. Si decides dar alguna tarea, SIEMPRE debe ser algo que la persona planteó en la sesión como una posible solución.
- De lo contrario, preparar una de las opciones del próximo punto.

RETROALIMENTACIÓN, TAREA Y CIERRE

Después del break, retomar la sesión:

1. Dar retroalimentación positiva tomando listado de fortalezas y recursos.
2. Enunciar tarea o UNA DE LAS SIGUIENTES FORMULACIONES:
   a) Le voy a pedir que de aquí a la próxima semana, usted se fije en las pequeñas cosas *que la ayuden a estar mejor y se fije en lo que usted hace.*
   b) De aquí a una semana, quiero que se fije en las cosas que usted hace y que le ayudan a *avanzar en esa escala y las repita. Cuando se da cuenta que algo pasa y que eso funcionó y repita esas acciones.*
   c) Cuando vea que las cosas van mejor, usted se fije que es lo que hizo usted que le sirva para avanzar desde el xx número que usted me dijo que está ahora hacia el número ideal.
   d) Quiero pedirle que aquí en adelante usted vea lo que funcione bien cuando las cosas estén mejor y después las haga de nuevo.
3. Pedir que llene la encuesta de cita. Chequear rápidamente si hay algo que la persona piensa que pudiera mejorar.
4. Preguntar si quisiera invitar a alguna persona cercana para la próxima sesión.

CHECKLIST: Una vez que te despidas del usuario/a, AUTOAPLICATE EL CHECK LIST DE LA SESION.

RECUERDA COMPLETAR LOS DATOS EN CADA HOJA. ¡GRACIAS!

Sesión 2

Antes de la sesión, asegurarse de tener los siguientes materiales:			
Grabadora	O	Encuesta de Cita	O
Check list	O	Registro de Sesión	O

*****RECORDAR QUE LA SESION SERA GRABADA** Y SI ES QUE SERÁ SUPERVISADO PEDIR CONSENTIMIENTO PARA ELLO.***

BIENVENIDA

Resumir y chequear si es que la imagen futura que la persona describió se mantiene, con el fin de encuadrar objetivo de sesión.

Preguntar: ¿Qué cosas han mejorado/ estado mejor en su vida, *respecto del problema que lo trajo acá*, desde que nos vimos la semana pasada *hasta hoy día*?

¿Qué tendría que pasar en esta sesión para que al final de nuestra conversación usted sienta que estamos avanzando hacia esa imagen futura?

PREGUNTAS DE ESCALA:

Pensemos en la escala de 1 a 10 donde 10 es la vida sin problemas y 1 es lo peor que podría estar ¿en qué número se encuentra hoy día?

PREGUNTA DE AFRONTAMIENTO:

¿Cómo lo hace/como lo ha hecho usted para estar en ese número y no más bajo?

BÚSQUEDA DE EXCEPCIONES:

Si ha aparecido tema de consumo de OH, podemos preguntar:

¿Ha habido veces en que siente que estuvo mejor respecto del consumo de_____ *(usar la palabra que la persona use: copete, trago, cerveza, chela, etc.)*? CUANTO MEJOR? EN QUE NUMERO DE LA ESCALA?

Ojo si es mujer. Puede que se sienta muy estigmatizada o que se sienta muy avergonzada o culpable, autoestima baja, etc. Empatizar, normalizar en términos de que a todas nos puede pasar, externalizar siempre.

Si no ha aparecido tema de consumo de OH, preguntar:

¿Ha habido veces en que siente que estuvo mejor QUE ESE NUMERO QUE USTED ME DICE? CUANTO MEJOR? EN QUÉ NUMERO DE LA ESCALA?

PREGUNTAS DE AFRONTAMIENTO:

¿Cómo lo hizo para estar mejor?

Y/o

¿Cómo se da cuenta que las cosas están mejor?

PREGUNTAS DE RELACION:

¿Quién se dio cuenta que las cosas están mejor? (POR QUÉ, COMO, CUANDO, QUE MÁS)

¿En qué número de la escala *cree usted* que las otras personas dirían que usted estaba cuando las cosas estuvieron mejor?

¿Por qué cree usted que ellos dirían que estaba en ese nivel? (DE QUÉ MANERA LES AFECTA?)

¿Cómo ellos se dan cuenta que usted estaba en ese número y no más bajo?

PREGUNTA CENTRADA EN EL FUTURO: CONSTRUCCION DE OBJETIVOS Y TAREAS A CORTO PLAZO:

De aquí a una semana:

Imagínese que viajamos a una semana después […] y las cosas están mejor ¿en qué número de la escala que hemos conversado se pondría usted?

Si estuvieran un poquito mejor las cosas de aquí a una semana, ¿en qué número estaría usted?

Fin de la sesión

Imagínese que estamos al final de la sesión y usted se va a su casa con la sensación que esta conversación fue útil, ¿cómo nota que fue útil?

24 horas

Piense en una cosa que usted podría hacer de aquí a mañana que le ayudaría en avanzar hacia ese xx que usted quiere.

¿Habrá alguna cosa que usted podría hacer de hoy día a mañana que le sirva para avanzar desde ese número hacia este 10… algo que usted podría hacer de aquí a mañana?

¿Qué podría ser una cosa que usted haga, dentro de las próximas 24 horas, que le ayude a estar mejor/avanzar?

BREAK

Quiero pedirle que tal como lo hicimos la vez anterior, nos tomemos unos minutos. Necesito resumir y ordenar lo que hemos conversado para luego darle algunas sugerencias y ver como seguimos para la próxima sesión. ¿Le parece? (ver si persona espera afuera o salir de la sala).

En este tiempo de alrededor de 5 minutos:

- hacer un listado de elogios tomando en cuenta todas las fortalezas y recursos de la persona/familia.
- revisar si es que amerita dar alguna tarea concreta en función de las respuestas que la persona elaboró con las preguntas centradas en el futuro. Si decides dar alguna tarea, SIEMPRE debe ser algo que la persona planteó en la sesión como una posible solución.
- De lo contrario, preparar una de las opciones del próximo punto.

RETROALIMENTACIÓN, TAREA Y CIERRE

Después del break, retomar la sesión:

1. Dar retroalimentación positiva tomando listado de fortalezas y recursos.
2. Enunciar tarea o UNA DE LAS SIGUIENTES FORMULACIONES:
   a) Le voy a pedir que de aquí a la próxima semana, usted se fije en las pequeñas cosas *que la ayuden a estar mejor y se fije en lo que usted hace.*
   b) De aquí a una semana, quiero que se fije en las cosas que usted hace y que le ayudan a *avanzar en esa escala y las repita. Cuando se da cuenta que algo pasa y que eso funcionó y repita esas acciones.*

c) Cuando vea que las cosas van mejor, usted se fije que es lo que hizo usted que le sirva para avanzar desde el xx número que usted me dijo que está ahora hacia el número ideal.
d) Quiero pedirle que aquí en adelante usted vea lo que funcione bien cuando las cosas estén mejor y después las haga de nuevo.

3. Pedir que llene la encuesta de cita. Chequear rápidamente si hay algo que la persona piensa que pudiera mejorar.
4. Preguntar si quisiera invitar a alguna persona cercana para la próxima sesión.

CHECKLIST: Una vez que te despidas del usuario/a, AUTOAPLICATE EL CHECK LIST DE LA SESION.

RECUERDA COMPLETAR LOS DATOS EN CADA HOJA. ¡GRACIAS!

Sesión 3

Antes de la sesión, asegurarse de tener los siguientes materiales:			
Grabadora	O	Encuesta de Cita	O
Check list	O	Registro de Sesión	O
Certificado de participación	O		

*****RECORDAR QUE LA SESION SERA GRABADA** Y SI ES QUE SERÁ SUPERVISADO PEDIR CONSENTIMIENTO PARA ELLO.***

BIENVENIDA

Resumir y chequear si es que la imagen futura que la persona describió se mantiene, con el fin de encuadrar objetivo de sesión.

Preguntar: ¿Qué cosas han mejorado/ estado mejor en su vida, *respecto del problema que lo trajo acá*, desde que nos vimos la semana pasada *hasta hoy día*?

¿Qué tendría que pasar en esta sesión para que al final de nuestra conversación usted sienta que estamos avanzando hacia esa imagen futura?

PREGUNTAS DE ESCALA:

Pensemos en la escala de 1 a 10 donde 10 es la vida sin problemas y 1 es lo peor que podría estar ¿en qué número se encuentra hoy día?

PREGUNTA DE AFRONTAMIENTO:

¿Cómo lo hace/como lo ha hecho usted para estar en ese número y no más bajo?

BÚSQUEDA DE EXCEPCIONES:

Si ha aparecido tema de consumo de OH, podemos preguntar:

¿Ha habido veces en que siente que estuvo mejor respecto del consumo de_____ *(usar la palabra que la persona use: copete, trago, cerveza, chela, etc.)*? CUANTO MEJOR? EN QUE NUMERO DE LA ESCALA?

Ojo si es mujer. Puede que se sienta muy estigmatizada o que se sienta muy avergonzada o culpable, autoestima baja, etc. Empatizar, normalizar en términos de que a todas nos puede pasar, externalizar siempre.

Si no ha aparecido tema de consumo de OH, preguntar:

¿Ha habido veces en que siente que estuvo mejor QUE ESE NUMERO QUE USTED ME DICE? CUANTO MEJOR? EN QUÉ NUMERO DE LA ESCALA?

PREGUNTAS DE AFRONTAMIENTO:

¿Cómo lo hizo para estar mejor?

Y/o

¿Cómo se da cuenta que las cosas están mejor?

PREGUNTAS DE RELACION:

¿Quién se dio cuenta que las cosas están mejor? (POR QUÉ, COMO, CUANDO, QUE MÁS)

¿En qué número de la escala *cree usted* que las otras personas dirían que usted estaba cuando las cosas estuvieron mejor?

¿Por qué cree usted que ellos dirían que estaba en ese nivel? (DE QUÉ MANERA LES AFECTA?)
¿Cómo ellos se dan cuenta que usted estaba en ese número y no más bajo?
PREGUNTA CENTRADA EN EL FUTURO: CONSTRUCCION DE OBJETIVOS Y TAREAS A CORTO PLAZO:
De aquí a una semana:
Imagínese que viajamos a una semana después […] y las cosas están mejor ¿en qué número de la escala que hemos conversado se pondría usted?
Si estuvieran un poquito mejor las cosas de aquí a una semana, ¿en qué número estaría usted?
Fin de la sesión
Imagínese que estamos al final de la sesión y usted se va a su casa con la sensación que esta conversación fue útil, ¿cómo nota que fue útil?
24 horas (escoger una)
Piense en una cosa que usted podría hacer de aquí a mañana que le ayudaría en avanzar hacia ese xx que usted quiere.
¿Habrá alguna cosa que usted podría hacer de hoy día a mañana que le sirva para avanzar desde ese número hacia este 10… algo que usted podría hacer de aquí a mañana?
¿Qué podría ser una cosa que usted haga, dentro de las próximas 24 horas, que le ayude a estar mejor/avanzar?
BREAK
Quiero pedirle que tal como lo hicimos la vez anterior, nos tomemos unos minutos. Necesito resumir y ordenar lo que hemos conversado para luego darle algunas sugerencias y ver como seguimos para la próxima sesión.
También quiero pedirle que esta vez usted se plantee algún compromiso que lo ayude a avanzar hacia su futuro deseado, eso que usted me ha contado durante estas semanas, y lo escriba en este certificado ¿Le parece? (entregar certificado de participación e indicar donde llenar compromiso).

En este tiempo de alrededor de 5 minutos:

- Hacer un listado de elogios tomando en cuenta todas las fortalezas y recursos de la persona/familia.
- Dado que en este caso, la persona formulará su propio compromiso, adoptar ese compromiso como la tarea. Y prepararse para apoyar a la persona a escribir detalles concretos de cómo lo hará.

RETROALIMENTACIÓN, TAREA Y CIERRE
*******dejar unos 20 minutos de la sesión tiempo para esta parte*******
Después del break, retomar la sesión:

1. Dar retroalimentación positiva tomando listado de fortalezas y recursos.
2. Preguntar por avances que el consultante percibe que ha tenido en estas semanas.
3. Resumir todos los avances que ha observado durante las sesiones y entre ellas.

4. Leer compromiso en conjunto y apoyar a describir COMO LO VA A HACER. De manera concreta: que acciones tomará, que va a estar haciendo que otra gente notará el cambio.
5. Firmar compromiso y felicitar por todos sus avances.
6. Enunciar UNA DE LAS SIGUIENTES FORMULACIONES:
   a) Cuando vea que las cosas van mejor, usted se fije que es lo que hizo usted que le sirva para avanzar desde el xx número que usted me dijo que está ahora hacia el número ideal.
   b) Quiero pedirle que aquí en adelante usted vea lo que funcione bien cuando las cosas estén mejor y después las haga de nuevo.
7. Pedir que llene la encuesta de cita. Chequear rápidamente si hay algo que la persona piensa que pudiera mejorar en el futuro con él u otra persona o familia.

Felicitar y despedirse.
Dejar abierta posibilidad de volver a seguimiento. Si es así, fijar cita para un mes más.

CHECKLIST: Una vez que te despidas del usuario/a, AUTOAPLICATE EL CHECK LIST DE LA SESION.

RECUERDA COMPLETAR LOS DATOS EN CADA HOJA. ¡GRACIAS!

CERTIFICADO DE PARTICIPACIÓN Y LOGRO

Se entrega el presente certificado a ..... por haber participado en un tratamiento breve centrado en soluciones y haber descubierto las siguientes fortalezas:

.....

.....

.....

Felicitamos a .....por haber logrado:

.....

.....

.....

.....

.....

COMPROMISO

De ahora en adelante, me comprometo a:

.....

.....

.....

.....

.....

_____ *Firma Participante*

_____ *Firma Trabajadora Social*

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